Horton Bank 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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Horton Bank Practice on 11 February 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, to report incidents and near misses. Information about safety was recorded, however, clear audit trails in respect of significant events and complaints were not in place.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Urgent appointments were usually available on the day they were requested.
- 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.
- The practice had a number of policies and procedures in place and held regular governance meetings.

We saw an area of outstanding practice:

- The practice provided GP appointments from 7.30 am every week day.

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 their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated to staff to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks could be improved. For example, there was not a robust audit trail and policy regarding significant events and complaints in place.

There were effective systems in place to manage medicines and prescribing.

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Patients who responded to CQC comment cards and those we spoke with during our inspection 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 that were available was easy to understand. We saw that staff treated patients with respect and maintained confidentiality.

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 and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available

Summary of findings

both in the practice and on the website. Learning from complaints was shared with staff. Urgent appointments were usually available on the same day and there was continuity of care. However, some patients said they had difficulty accessing the practice by telephone.

Are services well-led?

Good

The practice is rated as good for providing well-led services. 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. Patients and staff felt valued and a proactive approach was taken to involve and seek feedback from patients and staff. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that 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 was responsive to the needs of older people, offering home visits and longer appointments. There were systems in place for older people to receive regular health checks. Regular visits to local nursing home were also undertaken. The practice worked closely with other health care professionals, such as the community matron and district nursing team.

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. Longer appointments and home visits were available when needed. Patients had a structured annual review to check their health and medication needs were being met. There were systems in place to help ensure patients with multiple conditions received one annual recall appointment wherever possible. For those patients with the most complex needs, the clinical staff worked with relevant health and care professionals to deliver a multidisciplinary package of care. Specific clinics, such as diabetic, respiratory, warfarin, dietary and smoking cessation were held within the practice. The practice used the '9 steps of diabetes' pathway, which is specific to Bradford CCGs.

The practice had a system in place to follow up patients who had an unplanned hospital admission.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice held contraceptive and family planning clinics, maternity services and childhood immunisations clinics. At the time of our inspection a 'one stop shop' baby clinic was in operation which evidenced joint working between health visitors, a GP and practice nurse.

The practice provided sexual health support. Female GPs and clinical staff were trained to give contraceptive advice to patients.

The practice had a system in place to follow up any missed hospital appointments in relation to children

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 practice had extended hours, including pre-bookable early morning appointments, to facilitate attendance for patients who could not attend appointments during normal surgery hours. There were also online facilities for booking appointments and repeat prescribing.

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 had carried out annual health checks and offered longer appointments for people with a learning disability. There was access to translation services when needed and the website had a translation link to enable the site to be read in a language of their choice.

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 in-house counselling clinics, such as alcohol and debt, to support patients as appropriate.

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 or home visits were available. The practice had access to other professionals such as the local mental health team and psychiatric support as appropriate.

It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff were aware of how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We received three CQC comment cards. On the day of our inspection we spoke with three patients from various age groups, who had different physical and mental health needs and varying levels of contact with the practice.

The comments from the CQC comments cards told us they never felt rushed, that staff listened to them and were helpful and that they felt comforted and reassured.

The patients we spoke with said they were satisfied with the care they received, were treated with dignity and respect, felt listened to and were encouraged to see the same GP for an ongoing health condition. They also said they were happy with the cleanliness of the practice.

Outstanding practice

The practice provided GP appointments from 7.30 am every week day.

Horton Bank Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a second CQC inspector, a GP specialist advisor and a practice manager specialist advisor.

Background to Horton Bank Practice

Horton Bank Practice is situated within a purpose built building in the centre of a residential inner city area of Bradford. It was built in 1992 and provides a range of consulting and treatment rooms, with supporting administrative areas.

It provides Personal Medical Services (PMS) for a population of 7920 patients under a contract with NHS Bradford District Clinical Commissioning Group (CCG). The practice is registered to provide the following regulated activities: treatment of disease, disorder or injury; family planning; maternity and midwifery services; diagnostic and screening procedures.

There are three full time GP partners, one male and two female, and one part time salaried GP. There is a salaried GP vacancy which is currently covered by regular locums. The nursing team includes two practice nurses and a health care assistant who are all female. The practice also uses experienced locum nurse practitioners on a sessional basis to cover annual leave of clinical staff. There is an experienced team of 12 management, administrative and reception staff to support the practice. Horton Bank is a training practice accommodating both registrars and medical students.

The practice opening times are Monday to Friday 7.30am to 6pm. Patients can access the appointment system at reception, by telephone or online via the practice website. Some appointments are pre-bookable and others are bookable on the day. Out of hours care is provided by Local Care Direct, calls to the practice are automatically redirected to this service. Patients can also ring the service direct.

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

Please note that 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 CQC at that time.

How we carried out this inspection

Before visiting the practice we reviewed information we hold about the practice and asked other organisations, such as the NHS Bradford District CCG to share what they knew.

We carried out an announced inspection visit on the 11 February 2015. During our visit we spoke with a range of staff, including two GP partners, the practice manager, a

Detailed findings

practice nurse and two administration/reception staff. We also spoke with three patients who used the service and observed communication and interactions between staff and patients; both face to face and on the telephone. We reviewed three CQC comment cards where patients had shared their views and experiences of the practice. We also reviewed documents relating to the management of the practice.

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

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

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

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

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 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 saw evidence in minutes of clinical meetings where these were discussed. This showed the practice had managed these consistently and so could demonstrate a safe track record over the long term.

Learning and improvement from safety incidents

There were systems in place for how the practice managed safety alerts, significant events, incidents and accidents. We saw incident logs, covering the last twelve months, which identified what actions had been taken and learning implemented as a result. Staff we spoke to confirmed there was an open and transparent culture and they were aware of what incidents had taken place and the actions taken.

The practice manager showed us the system they used to manage and monitor incidents and there was a procedure in place for reporting these. We looked at records of reported incidents. Where patients had been affected by an incident we saw that, where applicable, action had been taken to protect patients' health and welfare. For example, we saw that there had been a failure to make a referral, the procedure had been reviewed and changed to ensure that risk of recurrence was minimised.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had designated GP leads in safeguarding vulnerable adults and children, who had completed level 3 training. We looked at training records which showed that all the staff had received relevant role specific training on safeguarding. Staff we spoke with were aware of their responsibilities and knew how to share information, record safeguarding concerns and how to contact the relevant agencies. Safeguarding policies and procedures and the contact details of relevant agencies were available and easily accessible for all staff.

A system was in place to highlight vulnerable patients on the practice's electronic record. The practice held monthly meetings with other agencies, such as the health visitor, to discuss concerns and share information about children and vulnerable patients who were registered at the practice.

Medicines management

The practice was supported by a pharmacist each week who gave advice on safe, effective prescribing of medicines. This included the checking and advising on medicines that needed regular monitoring and reviewing, such as warfarin. The pharmacist also supported the practice with audit and key performance indicators (KPIs) in relation to medicines management. There was a repeat prescribing protocol in place.

Requests for repeat prescriptions were taken in person at the reception desk, by post or over the internet. We were informed about checks that were made to ensure the correct patient was given the correct prescription. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and all prescription forms were kept securely.

There was a process to regularly review patients' repeat prescriptions to ensure they were still appropriate and to identify and contact patients who were either not ordering their repeat prescriptions or over ordering them. We were informed by staff and patients that medication was reviewed every six to twelve months, or more often depending on their individual condition.

The practice had arrangements for managing medicines, including recording, storage and disposal.

Vaccines were stored in locked refrigerators. Staff told us the procedure was to check the temperatures on a daily basis and record it. We saw evidence of daily records being kept. We were told vaccines were checked for expiry dates on a monthly basis and disposed of in line with the practice protocol. A selection of vaccines was looked at whereupon we found two boxes of Twinrix which had an expiry date of 1/15. A clinician told us that all vaccines and dates were

checked before giving to patients and these had been placed at the front of other vaccines to be disposed of in accordance with the practice policy. These were disposed of at the time of inspection.

Any changes in guidance about medications or medicine alerts were communicated to clinical staff and discussed at clinical meetings.

Cleanliness and infection control

We found the premises to be clean and tidy. We saw that two fabric chairs in one room were worn. We were advised at the time of inspection that these would be replaced by the end of February 2015. We saw there were cleaning schedules in place and records were kept. Patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness or infection control.

The practice had an infection prevention and control (IPC) policy which included management of needle stick injuries. Personal protective equipment, including disposable gloves and aprons, were available for staff to use. Hand washing sinks, antibacterial gel and hand towel dispensers were available in treatment rooms and hand gel was available for patients in the reception area. Sharps bins were appropriately located and labelled. The practice had access to spillage kits to enable staff to appropriately and effectively deal with any spillage of body fluids. Staff we spoke with were aware of the procedures in place to prevent cross infection and what to do in an incident.

We saw evidence that an IPC audit had taken place in February 2015. There was an overall score of 97.06%. There was a designated IPC lead and we saw evidence that all staff had received IPC training specific to their role.

Although we saw records that testing had been undertaken for legionella (a bacterium found in the environment which can contaminate water systems in buildings) the practice did not have a clear policy for the risk assessment, management, testing and investigation of legionella in line with Health and Safety Executive (HSE) guidance. The practice has since informed us that a date for legionella testing has been booked and a risk assessment is to be added to the IPC policy and audited.

Equipment

Staff we spoke with told us they had 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 records that confirmed this. We saw emergency equipment was available in the practice, which included emergency medicines.

There were systems in place for routine servicing and calibration of equipment where required. The sample of portable electrical equipment we inspected had up to date Portable Appliance Tests (PAT) completed, displaying stickers indicating the last testing date.

Staffing and recruitment

The practice had a recruitment policy. We looked at a sample of personnel files for the most recently employed clinical and non-clinical staff and saw that appropriate recruitment checks had been undertaken, which included evidence of photographic identification, references, appropriate qualifications for the role and criminal record checks through the Disclosure and Barring Service (DBS). The practice routinely checked the professional status of the GPs and practice nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) registers.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet the needs of patients. There was an arrangement in place for members of staff, including clinical and non-clinical, to cover each other's annual leave and sickness. The practice told us they used a small consistent group of GP and advanced nurse practitioner locums on a sessional basis to cover one of the GP's maternity 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. For example, the practice had a health and safety policy setting out the steps to take to protect staff and patients from the risk of harm or accidents and what to do in such an eventuality.

There was evidence of learning from incidents, responding to risk that had taken place and appropriate changes implemented. These were discussed at clinical, practice and other relevant meetings. For example, there had been a protected learning time (PLT) event for practice staff which discussed medical alerts, complaints and significant events relating to the practice. Staff told us that reflection

and learning was a regular occurrence. The practice also reported to external bodies such as the Clinical Commissioning Group (CCG), the local authority and NHS England in a timely manner.

The practice told us they responded to both identifiable and changing risks to patients, including deteriorating health and well-being. For example, patients who had a significant change in their condition, received a new diagnosis or had an unplanned hospital admission were discussed at clinical and MDT meetings. The practice also had a register of high risk patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's hear in an emergency). Members of staff told us they knew the location of the equipment and how to use it. We saw records confirming the equipment was checked regularly.

Emergency medicines were available in a secure area of the practice and staff we spoke with 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. All medicines checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included loss of access to the building, power failure, incapacity of staff, epidemic/ pandemic and response to a major incident. The document also contained relevant contact details for staff to refer to. For example, contact details of Yorkshire Water should there be a loss of water supply, these included telephone numbers for both normal and out of hours.

The practice told us about a recent incident which had occurred a few days prior to our inspection. There had been a power cut and the staff we spoke to described how they had implemented the continuity plan and were able to maintain a service for patients during that period.

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 best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told any updates were circulated and reviewed by the clinicians, changes made as required and discussed at team meetings. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the clinical staff that they completed thorough assessments of patients' needs in line with NICE guidance and these were reviewed when appropriate.

We were told that the GPs were encouraged to develop individual areas of interest in specialist clinical areas, for example cardiology. The nursing staff supported this work to meet the needs of those patients who had a long term condition, through specific clinics in line with their own knowledge and expertise. For example, a nurse we spoke with led a respiratory clinic where they supported patients who had asthma or chronic obstructive pulmonary disease (COPD).

The practice had registers for patients with long term conditions, including palliative care. This supported patients to have their conditions reviewed and monitored using standardised local and national templates. The nursing staff we spoke with told us they used personalised self-care management plans with patients as appropriate, raised awareness of health promotion and referred/ signposted to other services when required.

There were systems in place to identify and monitor the health of vulnerable groups of patients. We were told patients who had learning disabilities were given longer appointments, annual reviews were undertaken and consent documented. A clinician gave us an example where an issue of consent had arisen regarding a patient who had a learning disability and their carer, the decision making process and the outcome.

Interviews with staff showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of a patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing 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.

We were told that 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 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. This practice was not an outlier for any QOF (or other national) clinical targets.

The practice showed us a list of ten clinical audits that had been undertaken in the last twelve months. We looked at two of these in detail. Following each clinical audit, changes to treatment or care were made where appropriate and the audit to be repeated to ensure outcomes for patients had improved. The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. For example following changes to National Institute for Clinical Excellence (NICE) dyspepsia guidance, a clinical audit was carried out. The aim of the audit was to ensure the practice were following NICE guidance when requesting a gastroscopy. The first audit demonstrated that practice referral rates for gastroenterology were above average within their CCG. The information was shared with GPs. A second clinical audit was completed three months later which demonstrated a reduction in the number of inappropriate referrals for gastroscopy.

Are services effective?

(for example, treatment is effective)

To assist them to monitor prescribing practise and improve medicines management, the practice employed a pharmacist who completed regular audits against key performance indicators (KPIs). The pharmacist also reviewed medication changes which may have arisen from a hospital discharge, ensuring patients and their records were updated with any medication changes. The practice worked with the pharmacist to improve systems for repeat prescribing. There was a protocol for repeat prescribing and systems were in place to ensure that patients receiving repeat prescriptions were reviewed by a GP in line with national guidance. There were systems in place for the practice to follow up patients who were either not ordering repeat prescriptions enough or over ordering.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice had a Direct Enhanced Service (DES) for admission avoidance. There was a hospital avoidance register in place. Using a risk stratification toolkit the practice had identified the top 2% of patients who were most at risk of an unplanned hospital admission. We were told that all unplanned hospital admissions were reviewed within three days of receiving the information.

Effective staffing

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

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

The practice nurses were registered with the Nursing and Midwifery Council (NMC). To maintain registration they had to complete regular training, update their knowledge and maintain skills. The nurse we spoke with confirmed their professional development was up to date and training records reflected this.

The clinical and non-clinical staff confirmed they had annual appraisals. They told us it was an opportunity to discuss their performance and any training they either needed or wanted to attend. For example, a member of staff was being supported through registered nurse training. All the staff we spoke with felt they were very well supported in their role and confident in raising issues with the practice manager or GPs.

We observed staff were competent and knowledgeable about the roles they undertook.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those patients with complex needs. Procedures were in place to manage information from other services, such as hospitals and out of hours services (OOHs). Staff were aware of their responsibilities when processing discharge letters and test results. There were systems in place for these to be reviewed and acted upon where necessary by clinical staff. This included monitoring if patients did not attend appointments where they had been referred by the practice to other services. In these instances the practice would make contact with the patient or parent, in the case of a child.

The practice told us they held multidisciplinary team (MDT) meetings every two months to discuss the needs of palliative care patients. These meetings were attended by palliative care nurses and members of the district nursing team. In addition, other regular clinical meetings took place to discuss complex cases which included safeguarding. We saw evidence that health visitors were involved in these.

The practice operated a 'one stop' baby clinic where parent and child have access to a GP, practice nurse and a health visitor. At the time of our inspection a clinic was taking place and we saw evidence of multidisciplinary working between those clinicians.

The practice told us they received information from a local nursing home and Airedale Hospital via a tele-hub system. This system sent a task, via the computer, to the practice

Are services effective?

(for example, treatment is effective)

informing them of relevant information regarding elderly patients within that setting, enabling the practice to be kept up to date and provide care and treatment as necessary.

Information sharing

The practice used electronic systems to record and store patient data. Staff used an electronic patient record to co-ordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from the hospital, to be saved in the system for future reference.

We were shown condition management templates, policies and procedures that were available for clinical staff on the electronic system. These were updated using new guidance as appropriate.

Electronic systems were in place for making referrals and the GPs, in consultation with the patients, made referrals through the Choose and Book system. If this was not able to be undertaken at the time of consultation, the medical secretary was tasked the same day to contact the patient to book an appointment of their choice. (The Choose and Book system is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.) Staff reported this system was easy to use.

Consent to care and treatment

We found that the clinicians were aware of the Mental Capacity Act 2005 and Children Acts 1989 and 2004 and were able to describe how they implemented it in their practice. Although we could not find evidence that all staff had received training in this area, the clinical staff we spoke with understood the key parts of the legislation and confirmed their understanding of capacity assessments. Clinicians were able to give examples where consent for care and treatment had been discussed and mental capacity had been assessed and how it was recorded patient's electronic record. Clinicians told us discussions were held with patients to assure their consent prior to treatment or intervention. An example was given regarding a lack of consent in the case of a patient who had a learning disability, the decision making process and how it was recorded on that patient's electronic record.

Health promotion and prevention

The practice offered NHS Health Checks and were involved with national breast, bowel and cytology screening programmes. They also told us they participated in Bradford specific screening programmes, for example nine steps of diabetes and wheezy child pathway.

The practice offered a full range of immunisations for children, flu vaccinations and travel vaccinations in line with current national guidance.

The clinical staff told us how they promoted healthy lifestyles with patients and referred or signposted to other services. A practice nurse and health care assistant held smoking cessation clinics twice a week within the practice, where patients could be referred as appropriate. Additional services and clinics within the practice were available for patients, these included contraception, alcohol counselling, debt advice and mental health support or signposting to other appropriate services.

There was evidence of health promotion literature available in the clinical rooms and also in the reception area. The practice website also provided health promotion and prevention advice. For example, it had a link both to the website and leaflet of NHS Stay Well and also family health information. The information on the website could easily be translated into other languages via a translation link.

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 (January 2015), where from a survey of 339 questionnaires, 132 (39%) responses were received. This survey showed that 81% of respondents rated their overall experience of the practice as good. 94% of patients said that the nurse they saw treated them with care and concern, this was above average for the local CCG (88%).

Patients completed CQC comment cards to tell us what they thought about the practice. We received three completed cards which were positive about the service they experienced. We also spoke with three patients on the day of our inspection who told us that staff treated them with dignity and respect.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation/treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. During our inspection we saw a mother who wanted to breastfeed her child was offered a private room to maintain her privacy and dignity.

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatment so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. We observed that conversations between patients and staff at the reception could not be overheard. We also observed a notice in the reception area informing patients they could ask to speak somewhere private. Staff told us there was a room available which was used in those instances.

In the reception area and all the consulting rooms we entered we observed chaperone notices on display. Reception and administrative staff acted as chaperones and had undergone appropriate training. The staff we spoke to were aware of their duties and responsibilities when acting as a chaperone. We were told that if a reception staff was required to act as chaperone, they were given a badge identifying they were undertaking the role. Also that member of staff would not go back onto reception until the patient had left the building, in an attempt to minimise any potential for embarrassment to the patient.

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 good in these areas. For example, data from the national patient survey showed 84% of respondents said the GP involved them in care decisions and felt the GP was good at explaining treatment and results. Also 94% of respondents said the nurse they saw or spoke to was good at explaining tests and treatments, compared to the CCG average of 88%.

The patients we spoke with also 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.

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

Clinical staff told us that written care plans are undertaken in conjunction with patients who have a long term condition. These can include self-management plans. For example, patients who have asthma or Chronic Obstructive Pulmonary Disease (COPD) can be prescribed rescue medication with information of when and how to administer it and what to do in an emergency. We saw evidence of care plans for patients at risk of an acute hospital admission. These were reviewed every three months with the patient.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of the inspection told us staff were caring and provided support when required.

We saw information in the practice about support groups and organisations for patients to access. The practice website has further information for carers and a link to the local carers' resource website.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice told us that they engaged regularly with the local Clinical Commissioning Group (CCG) and other agencies to discuss the needs of patients and service improvements. The practice sought the views of patients through the Patient Participation Group (PPG) and through the friends and family test.

We found the practice was responsive to patients' 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.

The practice provided a service for all age and population groups. Longer GP and nurse appointments were made for those who needed them, for example people with learning disabilities or long term conditions. Home visits were also available for patients who found it difficult to access the surgery due to various physical or mental health issues, for example patients who had extreme anxiety.

Tackling inequity and promoting equality

The practice had recognised the needs of the different population groups in the planning of its services. For example, the practice had systems in place which alerted staff to patients with specific needs or who may be at risk. Home visits were offered and the practice had links with local residential care and nursing homes and a local care facility for people who have learning disabilities.

The practice had access to online and telephone translation services. The website also had a translate page function to enable patients to view the whole website in a language of their choice.

The practice was situated in purpose built premises. There were designated disabled parking spaces in the car park. There was access to the premises via a ramp and all patient areas and clinical rooms were on the ground floor. The patient areas were sufficiently spacious for wheelchair and pram access. Accessible toilet facilities were available for all patients, including baby changing facilities.

Access to the service

Information regarding the practice opening times and how to make appointments was available in the reception area and on the practice website. The opening times were 7.30am to 6pm Monday to Friday. Appointments were pre-bookable either by telephone, in person at the reception or via the practice website. There were also urgent same day appointments available.

Data from the national patient survey showed that 46% (CCG average 65%) of patients described their experience of making an appointment as good and 79% (CCG average 91%) said the last appointment they got was convenient. The practice told us they had looked at their current telephone system and how they could increase telephone access for patients making appointments. All the patients and staff we spoke with on the day of the inspection told us children and at risk patients were given same day appointments.

Nursing staff told us that they would often fit additional patients in their clinics as the need arose. Staff also told us that patients could ring and ask to speak to a specific GP. One patient told us that a GP had telephoned them back regarding health care advice. We were told that everyone was seen on the day who presented as an emergency and that all the GPs were available in the practice every weekday to support continuity of care.

The practice also encouraged patients to cancel their appointments if they no longer required them. This could be done by telephone, in person or via a text messaging service.

Information was available in the practice and on their website regarding out of hours care provision when the practice was closed.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was 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 both in the reception area and on the practice website. We were shown a complaints form that we were told was completed at the time of a complaint being made. Patients we spoke with were aware of how to make a complaint but none of them had ever needed to make a complaint about the practice.

Are services responsive to people's needs?

(for example, to feedback?)

We looked at how complaints received by the practice in the last twelve months had been managed. We saw that nine complaints had been received. The records showed that the complaints had been dealt with and apologies given to patients where appropriate, but it wasn't clear whether patients had been given information on how to escalate their complaint if they were not satisfied with the response. Also there wasn't a clear audit trail. For example, no date to say when the complaint had been actioned, who was responsible for completing any required actions and a review of the impact of any changes to service the action may have had.

Staff told us learning from complaints had been shared with them and we saw minutes from meetings that evidenced that.

Are services well-led?

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

Our findings

Vision and strategy

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 and had a mission statement on their website.

All staff told us that the practice vision and values were embedded within the culture of the practice. They told us that the practice was patient focused. They spoke positively about leadership and felt valued as employees.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. We found that not all of these had a record to identify who reviewed the policies and when the review date was. For example, the chaperone policy and repeat prescribing policy.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at practice meetings.

The practice had an ongoing programme of clinical audits which were used to monitor quality, ensure the practice was achieving targets and delivering safe, effective, caring, responsive and well-led care.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection prevention and control and a lead GP for safeguarding children and adults. The staff we spoke with all understood their roles and responsibilities and knew who to go in the practice with any concerns.

We found that the management team and staff continually looked to improve the service being offered. Regular meetings were undertaken where governance, quality and risk were discussed.

The practice had arrangements for identifying, recording and managing risks. We saw that risk assessments had been carried out and actions implemented.

Leadership, openness and transparency

The staff we spoke with told us that all members of the management team were approachable, supportive and appreciative of their work. Staff also spoke positively about the practice and how they worked collaboratively with colleagues and health care professionals. The practice held regular staff meetings and staff told us they had opportunity to discuss any issues, ideas or concerns they had. We saw that there was good communication between staff members.

The practice was committed to the continuing education, learning and development of staff. A practice nurse told us about a peer group within the CCG that the practice supported them to attend. We were told that staff could identify training needs as it became relevant to their role and through annual appraisal.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the most recent annual patient survey of which the main issue was access to the practice by telephone. We saw through minutes of meetings this had been discussed with practice staff. There was also an action plan (dated January 2015) for the practice to look into either a new phone system or change the options available, with a date of completion being six months.

All patient survey results and action plans were available on the practice website. The practice also participated in the Friend and Family test and information was available both in the practice and on their website.

The practice had an active Patient Participation Group (PPG) of approximately twenty members from various population groups, which was supported by the practice. The group had identified the use of a newsletter as being a useful communication tool for patients. We saw evidence that the practice had produced a newsletter in response.

Staff feedback was gathered at regular practice meetings and through annual appraisals. Staff told us they felt comfortable in giving feedback or raising any concerns. Staff told us they felt involved and engaged in the practice to improve outcomes for both patients and staff.

Management lead through learning and improvement

Are services well-led?

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

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The practice was also a training practice for GP registrars and medical students.

Staff told us that annual appraisals took place, which included a personal development plan. This was evidenced in the five staff files we looked at.

The practice had completed reviews of significant events and other incidents and shared the information at staff meetings to ensure the practice improved outcomes for patients.

The practice also had monthly protected learning time (PLT) events for practice staff. Alongside educational sessions, these events included looking at and learning from significant events, complaints and the results of patient surveys. The practice manager showed us agendas and minutes from two PLTs.