Little Horton Lane Medical Centre - Mall

Quality Report

Little Horton Lane
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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 visit on 4 November 2014 and the overall rating for the practice was good. The inspection team found after analysing all of the evidence that the practice was safe, effective, caring, responsive and well led.

Our key findings were as follows:

- The practice provided good, safe, responsive and effective care for all population groups in the area it serves.
- All areas of the practice were visibly clean.
- Where incidents had been identified relating to safety, staff had been made aware of the outcome and action taken where appropriate, to keep patients and staff safe.
- Patients received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to ensure they were up to date with best practice.
- The service was responsive and ensured patients received accessible, individual care, whilst respecting their needs and wishes.
- The service was well led and there were positive working relationships between staff and other healthcare professionals involved in the delivery of service.

We saw several areas of outstanding practice these included:

- The practice is providing rapid and quality care provision, for ultra sound scanning and anticoagulation clinics. This service is called ‘at the patients’ doorstep’ and is available for other GP practices patients.
- The practice is working with the hospital to screen patients for Hepatitis B & C.
- The practice is opening on Saturday mornings during the winter months to reduce hospital pressures.
- There is a named staff lead who actively works with the PPG to improve patient care.

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 (NICE) and used it routinely. Patients' 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 roles and further training needs were in the process of being identified and planned. The practice could identify appraisals and some personal development plans for staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients 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 also saw staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Not all patients found it easy to make an appointment with a named GP although they felt there was continuity of care. However we were told urgent appointments were available the same day.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. They learnt from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a leadership structure in place and staff felt supported by the management team. The practice had a number of policies and procedures to govern activity and held regular governance meetings. The practice were pro-actively updating all policies to meet the ever changing demands of General Practice. 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 participation group (PPG) was active. Staff had received inductions, 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 patients. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example end of life care. It was responsive to the needs of older patients and offered home visits and rapid access appointments where needed.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and 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 named GP worked with relevant health and care professionals to deliver a multi-disciplinary package of care.

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 and who were at risk, for example, children and young patients who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young patients were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age patients (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for patients with a learning disability and 100% of these patients had received a follow-up. The practice offered longer appointments where needed for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing and the documentation of safeguarding concerns. They were able to describe how to contact relevant agencies in normal working hours and out of hours.

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). This included ensuring annual physical health checks where attended. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND. 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 had received training on how to care for patients with mental health needs and dementia.

Summary of findings

What people who use the service say

We received 39 completed CQC patient comments cards. We spoke with three patients on the day of the inspection. We were unable to speak with a member of the Patient Participation Group (PPG) on the day; however we spoke with a member at a later date.

The patients spoke highly of the care provided by staff; they said everyone was kind, they felt listened to and overall satisfaction was constantly mentioned. All patients said they were involved and felt supported in the planning and decisions about their care. They felt the clinical staff were knowledgeable about their treatment needs and they were given a caring, compassionate and efficient service. They told us the reception staff were welcoming, helpful and efficient. Overall they felt the communication skills of the staff was really good.

Patients reported staff treated them with dignity and respect and they were given support and information to cope emotionally with any care or treatment. Patients said the practice met their needs and was very good. They felt their views were valued by the practice and they were listened to. However out of the 39 CQC comment cards, 13 patients commented on the difficulties in arranging appointments.

Outstanding practice

- The practice is providing rapid and quality care provision, for ultra sound scanning and anticoagulation clinics. This service is called ‘at the patients’ doorstep’ and is available for other GP practices patients.
- The practice is working with the hospital to screen patients for Hepatitis B & C to improve the health of their practice population.
- The practice is opening on Saturday mornings during the winter months to help reduce hospital pressures.
- There is a named staff lead who actively works with the PPG to improve patient care.

Little Horton Lane Medical Centre - Mall

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 GP specialist advisor, a practice manager and a CQC inspector.

Background to Little Horton Lane Medical Centre - Mall

Dr Mall and partners surgery is located in the Little Horton Lane Medical Centre Bradford and provides primary care services to 4135 patients. Over ninety per cent of the practice population are under 60 years of age. There is disabled access at the front of the building and parking is available.

The practice is registered with the CQC to provide the following regulated activities: diagnostic and screening, family planning, maternity and midwifery and treatment of disease or injury.

The practice has three male GP partners. Working alongside this GP is a part time female practice nurse and a part time female health care assistant. There is a practice manager who is supported by a team of administrators and reception staff within the practice. Staff are supported through an annual appraisal system and training.

The practice has a Personal Medical Services (PMS) contract. PMS is a locally agreed alternative to General Medical Service (GMS) for providers of general practice.

The practice is open Monday to Friday 8:00 am to 6:00pm. The practice has late clinics every Monday from 6:30 to 8.00pm. A range of appointments are available, including telephone consultation with a GP and urgent appointments on the same day. Patients are able to book these in person or over the phone. The practice also offers home visits for patients who are unable to attend the practice. When the practice is closed the Out of Hours service for Bradford supports the patients.

A wide range of practice nurse led clinics are available for patients at the practice. These include vaccinations and immunisations, cervical smears, family planning, removal of sutures and clips, and chronic disease management such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and heart disease. The midwife, a health advisor and counsellor, an alcohol advisor and a dietician all provide regular clinics at the practice. The practice has commissioned the Pharmacy First Scheme for minor ailments to ease patient access to appointments.

Why we carried out this inspection

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

Detailed findings

We inspected this service as part of our new inspection programme covering Clinical Commissioning Groups throughout the country. Little Horton Medical Centre, Dr Mall & partners is part of the Bradford City CCG and was randomly selected from the practices in the area.

How we carried out this inspection

Before visiting, Little Horton Medical Centre, Dr Mall & partners we reviewed information we hold about the practice and asked other organisations to share what they knew. We asked the practice to provide us with a range of policies and procedures and other relevant information before the inspection to enable us to have an overview of the practice. We carried out an announced visit on 4 November 2014. During our inspection we spoke with staff including GPs, the data quality lead, practice nurse, administration and reception staff. We spoke with three patients who used the service and later we spoke with a member of the Practice Participation Group (PPG). A PPG is a group of volunteer patients who meet with the practice manager and GPs to discuss the services provided by the practice. We observed how patients were being spoken with and talked with carers and family members. We reviewed CQC comment cards where patients shared their views and experiences of the service.

Information from the General Practice Outcome Standards (GPOS), Quality Outcomes Framework (QOF) and Bradford City Clinical Commissioning Group (CCG) information showed the practice rated as an achieving 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)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. This information included reported incidents, national patient safety alerts as well as comments and complaints received from patients. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2012-2013 the practice was appropriately identifying and reporting incidents.

Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. The practice had developed clear lines of accountability for all aspects of patient care and treatment. The GPs and nurses had lead roles such as a medicine lead and an infection control lead. Each clinical lead had systems for monitoring their areas of responsibility, such as routine checks to ensure staff were using the latest guidance and protocols in their treatment of patients.

Safety was monitored using information from a range of sources including the QOF, patient survey results, patient feedback forms, the Patient Participation Group (PPG), clinical audit, appraisals, professional development planning, education and training. We reviewed safety records and incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could demonstrate a safe track record over the long term.

There were comprehensive policies and protocols for safeguarding vulnerable adults and children. Any concerns regarding the safeguarding of patients were passed on to the relevant authorities by staff as quickly as possible.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred and these were made available to us. Significant events were discussed at the practice meeting. We saw all events had been brought to a satisfactory conclusion and that actions were implemented as a consequence to prevent recurrence. There was evidence that appropriate learning had taken place and that the findings were shared with relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Reliable safety systems and processes including safeguarding

There were policies and protocols for safeguarding vulnerable adults and children. Concerns regarding the safeguarding of patients were passed on to the relevant authorities by staff as quickly as possible.

Staff had received training relevant to their role and this included safeguarding vulnerable adults and children training. The lead GP informed us they had participated in local safeguarding meetings for their patients, when required. We saw that alerts were placed on patients' electronic records to inform staff of any safeguarding issues for individual patients who attended for consultation.

We saw an up to date chaperone policy and protocol. We were told the administration staff had chaperone training.

Medicines management

The practice was supported by a pharmacist who helped with prescribing audits to ensure patients received appropriate medicines. We saw the 2013/2014 prescribing audit visit report which identified the positive changes had been undertaken within the practice. There were appropriately stocked medicine and equipment bags ready for doctors to take on home visits. One doctor's bag was checked and we found the contents were safety sealed and in date.

The GPs told us that they received medicine alerts from the Clinical Commissioning Group (CCG), National Institute for Health and Care Excellence (NICE) and Medicines Products Regulatory Agency (MHRA). Any changes in guidance about medicines were communicated to clinical staff in practice meetings. We were told that where there had been changes to guidelines for some medicines, audits had been completed.

Medicine fridge temperatures were checked and recorded daily. The fridges were adequately maintained by the manufacturer and the staff were aware of the actions to take if the fridges were ever found to be out of the correct temperature range.

There were standard operating procedures (SOP) in place for the use of certain medicines and equipment. The nurses

used patient group directives (PGD). PGDs are specific written instructions which allow some registered health professionals to supply and/or administer a specified medicine to a predefined group of patients, without them having to see a doctor for treatment. For example, flu vaccines and holiday immunisations. PGDs ensured all clinical staff followed the same procedures and do so safely. The SOPs and PGDs we saw were in date and clearly marked, which helped staff identify and refer to the correct document. So patients can be assured they received their medicines safely and in line with guidance produced by the National Institute for Health and Care Excellence (NICE).

The practice did not provide a dedicated prescription telephone line, however their web site and practice leaflet explained that patients could request repeat prescriptions either on-line, in writing or in person at the practice. When changes were requested to patients' prescriptions by other health professionals such as NHS consultants and/or following hospital discharge, the practice updated their records to reflect this.

Cleanliness and infection control

We were told the practice had an infection control policy and guidelines in place. This meant staff had guidance to refer to should they need assistance in the systems and processes to use in the management of infection prevention control (IPC). The policy provided staff with information regarding infection prevention, including hand hygiene, sharps injury, personal protective equipment (PPE) and single use medical devices. All staff had completed training in IPC. Audits of the IPC processes were to be completed annually and the policy was to be reviewed.

Standards of cleanliness and hygiene were maintained at the practice. We observed most areas of the practice to be visibly clean and tidy. Cleaning schedules were available. Colour coded cleaning cloths and mops were used to avoid the risk of cross contamination/infection.

We saw the hand washing facilities, hand gel dispensers; paper towels and instructions about hand hygiene were available throughout the practice. We saw clinical bins were foot operated and clinical waste was segregated from ordinary waste. We were told the practice did not use any instruments which required decontamination between patients and that all instruments were single use. We observed the practice had stocks of instruments and that these were within their expiry date.

The sharps bins were appropriately assembled, they signed and dated in accordance with IPC guidance. Personal protective equipment (PPE) such as disposable gloves and aprons were available in the examination areas. We also saw spillage kits which would be used to enable staff to appropriately deal with any spillage of body fluids.

We did not see any evidence of legionella testing documentation at our inspection. However the practice was taking steps to assure that they were compliant with Health and Safety Building Regulations and British Standards.

Equipment

The maintenance and use of equipment kept patients safe. Emergency equipment included a defibrillator and oxygen which was readily available for use in a medical emergency. We saw they had been checked regularly to ensure they were in working condition.

We saw that equipment had up to date portable appliance tests (PAT) completed and systems were in place for routine servicing and calibration of equipment where required.

Equipment was clean and functional. Items were labelled with the last service date.

Staffing and recruitment

The practice had a recruitment policy which had been reviewed in September 2014. We looked at the staff file for the most recent staff member employed and found it to be comprehensive and well

maintained. All appropriate checks were carried out before the staff member began working within the practice. Clinical staff had recent Disclosure and Barring Service checks (DBS) in line with the recruitment policy. We checked other staff files and found them to be well maintained. They contained appropriate curriculum vitaes and references and sufficient checks to ensure the person was suitable to carry out the duties required in their role. All staff had their clinical qualifications recorded and checked on an annual basis or on renewal of their professional registration.

Staff had appraisal documents available in their files and they told us the process was very supportive. They were able to ask for relevant training for their role. All staff were aware of the policy for study and training leave and told us they were granted study leave in line with this process.

Good

Are services safe?

Monitoring safety and responding to risk

The practice had arrangements for monitoring safety and responding to changes in risk to keep patients safe. There were systems in place to monitor safety in the practice and report problems that occurred. The practice had developed clear lines of accountability for all aspects of patient care and treatment.

Areas of individual risk were identified. Posters relating to safeguarding and violence/ aggression were displayed. The appointment systems allowed for a responsive approach to risk management. For example, we were told by staff and saw information in the practice leaflet that appointments were reserved each day for "On the day" emergencies. We were told everyone was seen on the day who presented as an emergency.

Arrangements were in place to protect patients and staff from harm in the event of a fire. This included staff designated as fire wardens and carrying out appropriate fire equipment checks and holding regular fire drills.

There was evidence learning from incidents and responding to risk had taken place and appropriate changes implemented. The practice management team looked at safety incidents and any concerns raised. They then looked at how this could have been managed better or avoided. They also reported to external bodies such as the Clinical Commissioning Groups (CCG), the local authority and NHS England in a timely manner.

Up to date emergency equipment and drugs were checked and we found they were readily available for use in an emergency. Staff spoken with and records seen, confirmed that all staff had received training in medical emergencies including resuscitation techniques. All staff were trained in basic life support and the clinical staff in the treatment of anaphylactic shock (severe allergic reaction).

Arrangements to deal with emergencies and major incidents

There were disaster/ business continuity plans in place to deal with emergencies that may interrupt the smooth running of the service such as power cuts and adverse weather conditions. The plans were accessible to all staff and kept in reception. The plan included an assessment of potential risks that could affect the day-to-day running of the practice. This provided information about contingency arrangements staff would follow in the event of a foreseeable emergency. We were also told of a recent incident where a patient had become unwell and how the emergency plan had been implemented successfully.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients were involved in decisions about their care and treatment. The clinicians were familiar with and were following current best practice guidance. New guidance from the National Institute for Health and Care Excellence (NICE) was reviewed at the regular clinicians' meetings and where appropriate, a plan made to implement into clinical practice. Individual clinicians lead on specific disease areas, such as diabetes. We saw The British Thoracic Society (BTS) guidelines informed the care and treatment of patients who suffered from asthma.

From our discussions we found GPs and nurses were aware of the latest best practice guidelines and incorporated this into their day-to-day practices. Protocols from the local NHS trust were available and used to assist staff in maintaining the treatment plans of their patients. The practice used standardised local/national best practice care templates as well as personalised self-management care plans for patients with long-term conditions. This supported the practice nurse to agree and set goals with patients these were monitored at subsequent visits. There were Bradford specific screening programmes in place, such as diabetes and for hepatitis B and C, to ensure patients were supported with their health needs in a timely way.

The practice raised awareness of health promotion during consultations with GPs and nurses. They also had health promotional literature available in the treatment rooms, the practice waiting areas and displayed on the practice web site.

Management, monitoring and improving outcomes for people

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF). The QOF aimed to improve positive outcomes for a range of conditions such as diabetes and high blood pressure. The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients and was used to monitor the quality of services provided.

We found clinical staff had a good awareness of recognised national guidelines. For instance they used National Institute for Health and Care Excellence (NICE) quality standards and best practice in the management of conditions such as diabetes and asthma. The practice had a system in place for completing clinical audit cycles. Examples of clinical audits were seen .

We saw minutes of practice meetings where new guidelines were shared and the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidance, and these were reviewed when appropriate.

The practice completed full health checks on new patients and follow up support for any identified health needs. Special clinics for health needs such as, coronary heart disease, diabetes, asthma and COPD were held and systems were in place to identify patients who met the criteria to attend.

Mothers and babies were supported with antenatal clinics, health visitor support and child health and immunisation clinics.

Feedback from patients confirmed they were referred to other services or hospital when required. National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for referral, for instance two week referrals for patients with suspected cancer were done there and then, and other routine referrals were done within seven days.

Effective staffing

Staff had the skills, knowledge, qualifications and experience to deliver effective care and treatment. Staff received appropriate training to meet their learning needs and to cover the scope of their work. We were able to review staff training records and we saw that this covered a wide range of topics such as equality and diversity, health and safety and infection control. The practice ensured all staff could readily update both mandatory and non-mandatory training and this was provided through e-learning and face to face training. Newly employed staff were supported in the first few weeks of working in the practice. An induction programme included time to read the practice's policies and procedures.

Good

Are services effective?

(for example, treatment is effective)

There were systems in place to assess the clinical performance of staff via clinical supervision and staff meetings. Appraisals were in the process of being updated for all staff. We found that staff raised and shared concerns, incidents were reflected upon and learning took place to improve the outcomes for patients.

The GPs in the practice were registered with the General Medical Council (GMC) and were required to undertake regular training and to update their skills. We saw evidence of the GPs revalidations and their 360° feedback which was extremely positive from staff, patients and colleagues. The nurses in the practice were registered with the Nursing and Midwifery Council (NMC). To maintain their registration they must also undertake regular training and updating of their skills.

Working with colleagues and other services

We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. There were regular monthly meetings with the multi-disciplinary team within the locality. This included district nurses and health visitors. There were also regular informal discussions with these staff. This helped to share important information about patients including those who were most vulnerable and high risk.

The practice had systems in place for recording information from other health care providers. This included out of hours services and secondary care providers, such as hospitals. A named member of staff was responsible for ensuring the information was disseminated appropriately. We spoke with practice staff about the formal arrangements for working with other health services, such as consultants and hospitals. They told us about how the practice referred patients for secondary (hospital) care. When a referral was identified, the practice always tried to book an appointment, using the, 'choose and book' system. There was an identified member of the team who was responsible for this and they told us what they did to ensure appropriate appointments were made.

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

Information sharing

The practice staff worked closely with the local community nursing team which included the health visitor. Monthly meetings were held and a member of the palliative care team also attended when necessary. At these meetings, individual patients and the care they were receiving from each professional group was discussed and records updated.

There was a system in place to ensure the out of hours service and NHS 111 had access to up-to-date treatment plans of patients who were receiving specialist support or palliative care. This ensured care plans were followed, along with any advanced decisions patients had asked to be recorded in their care plan.

Consent to care and treatment

We found the healthcare professionals understood the purpose of the Mental Capacity Act (2005) and the Children Act (1989) and (2004). They confirmed their understanding of capacity assessments and how these were an integral part of clinical practice. They also spoke with confidence about Gillick competency assessments of children and young people, which were used to check whether these

patients had the maturity to make decisions about their treatment. All staff we spoke with understood the principles of gaining consent including issues relating to capacity. We saw information relating to the five principles to be considered when seeking consent in each clinical room.

Clinical staff were able to confirm how to make 'best interest' decisions for patients who lacked capacity and how to seek appropriate approval for treatments such as vaccinations from children's legal guardians. The practice had a consent policy available to assist all staff and this provided them with access to relevant consent form templates. Patients felt they could make an informed decision. They confirmed their consent was always sought and obtained before any examinations were conducted. They told us about the process for requesting and using a chaperone and felt confident that it was effective as it was available to them when needed.

Health promotion and prevention

Patients were supported to live healthier lives. New patients at the practice were given an appointment at

Good

Are services effective?

(for example, treatment is effective)

registration, which was used as an opportunity to identify potential risks to the patient's health. Patients' individual needs were assessed and access to support and treatment was available as soon as possible.

The practice had a health trainer to support with health promotion initiatives these included: weight management, smoking cessation and alcohol use. A dietician held clinics within the practice for patients with diabetes.

The practice nurse team led on the management of long-term conditions (LTCs) of the patients in the practice.

They proactively gathered information on the types of LTCs patients present with and they had a clear understanding of the number and prevalence of conditions being managed by the practice.

We saw the 'call and recall' system and how this worked within the surgery. This helped to ensure the timely and appropriate review of patients with LTCs and those who required periodic monitoring. Patients with more than one LTC were offered one recall appointment when all care and treatment could be reviewed. This included an appointment time which was longer to improve the patient experience.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in rooms which gave patients privacy and dignity. Patients at the practice told us they were treated with kindness, dignity, respect and compassion whilst they received care and treatment. They told us they were able to have confidential discussions with staff at reception and there was a room available to talk with staff in private should they choose to. They said that they had access to language line should they need it.

We saw the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. We saw there was a notice in reception about courtesy and respect when patients were waiting to book in. We were told this worked well by reception staff and the Patient Participation Group (PPG) member.

The practice had a chaperone procedure in place to support patients. There were signs prominently displayed in the reception and waiting room explaining that patients could ask for a chaperone during examinations if they wanted one. The healthcare assistant and members of the reception team had received chaperone training.

Care planning and involvement in decisions about care and treatment

The patients we spoke with said they had been involved in decisions about their care and treatment. They told us their treatment was fully explained to them and they understood the information. They felt the nurses and GPs would take time to re-word information if they did not understand.

We saw care plans for patients with specific health needs. They were adapted to meet the needs of each individual. This information was designed to help patients to manage their own health, care and wellbeing to maximise their independence. The practice were working hard to engage the practice population to understand the partnership of care. Additionally those patients who needed support from carers could be assured that their needs would be met because of the careful care planning. There was evidence that these care plans were having an impact on reduced hospital admissions.

Staff recognised when patients who used the practice and those close to them needed additional support to help them understand or be involved in their care and treatment. The staff team were multi-lingual and had access to further interpretation services, when needed.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection told us staff were caring and understanding when they needed help and provided support where required. The CQC patient comments cards also confirmed that all of the practice staff were very supportive to them and their families.

Notices in the patient waiting room and patient website also signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. There was written information available for carers to ensure they understood the support available. We also saw the practice's November newsletter which had further details about care and support which was available locally.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Care and treatment was planned and delivered to meet the needs of patients. Patients we spoke with told us the practice was providing a service that met their needs. The practice regularly sought the views of patients through the patient suggestion box, patient survey and the Patient Participation Group (PPG) which enabled patients to voice their concerns and needs.

The PPG was supported by an identified member of the practice team. They had protected time to contact the members, to encourage other participants and to arrange speakers who would meet the needs of the practice population.

Patients with immediate, or life-limiting needs, were discussed at the weekly clinical meeting to ensure all practitioners involved in their care delivery were up-to-date and knew of any changes to their care needs. There was a register for patients with learning difficulties and they were offered annual health assessments.

Tackling inequity and promoting equality

Patients who needed extra support because of their complex needs were allocated double appointments. We saw specific tailored care plans to meet their needs for example patients with learning disabilities or those who had long term conditions such as diabetes.

The practice provides rapid and quality care provision, at the patients' doorstep, for ultra sound scanning and anticoagulation clinics. In addition the practice worked with the hospital to screen patients for Hepatitis B & C to improve the health of their practice population.

Access to the service

There was a large on-site car park. The practice was accessible to patients with mobility difficulties. The consulting rooms were large with easy access for patients with mobility difficulties. All consulting rooms were located on the ground floor. There where toilets for disabled patients. There was a waiting area with plenty of space for wheelchair users.

A range of appointments were available for patients, including telephone consultation with a GP where appropriate, urgent appointments on the same day and home visits. The practice supported patients to access appointments through telephoning the surgery or attending in person. The practice also offered home visits for patients who were unable to attend the practice. The practice opened on Saturday mornings during the winter months to help reduce hospital pressures.

Of the 39 CQC patient comment cards, we received 13 commented on the difficulties of phoning for an appointment. The GPs told us they were to look into adding a service to the telephone which would alert patients to their place in the queue. This they felt would alleviate some of the frustrations felt about the engaged tone. Patients told us when appointments were available and they would be seen quite quickly. We confirmed with one member of the PPG that the GP's were responsive to suggestions. For instance extending openings on Mondays to support patients access to more appointments.

Listening and learning from concerns and complaints

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

We reviewed a record of complaints for the practice and saw that there were systems in place for reporting and receiving complaints. We were informed that a company was booked the day after our inspection to provide assistance with policy maintenance and to review the procedures currently in place. We were told the outcomes of complaints, actions required and lessons learned were shared with the staff during their team meetings. The outcomes and any areas for improvement were also discussed at the PPG.

The complaints procedure was available to patients in the practice booklet and on noticeboards in the waiting room. The patients we spoke with were happy with the care they received at the practice and they knew how to make a complaint should they need to. They also felt they would be listened to.

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

There was an established management structure within the practice. The GPs and staff we spoke with were clear about their roles and responsibilities. The practice was committed to deliver a service where patient care came first. However, they were aware that their current model maybe unsustainable and they were pro-actively working with the CCG and other practices locally to ensure their vision of primary care continues. They were also very clear about providing a rewarding place to work and ensuring a healthy/work life balance.

Governance arrangements

There was a management structure with clear allocations of responsibilities. Staff we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

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

Care and treatment was provided by the multi-disciplinary team all the team members met monthly and practice meetings every three months.

Leadership, openness and transparency

The practice encouraged candour, openness and honesty, with regular meetings where challenge and debate could happen. All staff attended staff meetings and they told us that they were able to voice their opinions and felt listened to. The minutes of the meetings reviewed showed staff regularly attended meetings and these provided them with the opportunity to discuss the service being delivered. Staff we spoke with told us their wellbeing was good. They said that as a team they supported each other and felt looked after by the management of the practice.

We saw the minutes of integrated care team meetings, where members of the wider multi-disciplinary teams attended to discuss care and treatment of the patients they supported. Members of this team included social workers, community matrons, palliative care nurse, members from the carers resource team and mental health care workers.

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

The practice had conducted a patient survey. The evidence from this showed patients were satisfied with the care and treatment provided by the practice and how they were treated. We received 39 completed CQC comment cards. The patients were complimentary about the care provided by the clinical staff and the overall friendliness and behaviour of staff.

Staff were very engaged with and committed to the practice and its patients. They spoke passionately about their roles and the patients and how they were supported to give patients the best care possible

Each member of staff we spoke with felt they had a voice and the practice was interested in creating a learning and supportive working environment.

The Patient Participation Group(PPG) was actively supported by a named member of the practice team. They held monthly meetings where concerns were explored and brought to the GPs attention. We were told issues were attended to in a timely way. A monthly newsletter was produced to inform of any changes within the practice and included the non-attendance of appointments which had been made and not kept. It also alerted patients to use the suggestion box located in the waiting room.

Management lead through learning and improvement

We saw that an induction programme was completed by new staff and that all staff had completed mandatory training. This included: fire safety awareness, information governance, safeguarding vulnerable adults and children and equality and diversity. The practice had clear expectations of staff attending refresher training and this was completed in line with national expectations. We were told the practice held a record of all training undertaken and details of when refresher training would be required.

Are services well-led?

Good

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

Staff told us the training they received helped to improve outcomes for the patients. The staff we spoke with told us they felt supported to complete training and could request any additional training which would benefit their role.

The practice used information such as the Quality Outcome Framework (QOF) & patient feedback to continuously improve the quality of services. Staff were able to take time out to work together to resolve problems and share information which was used proactively to improve the quality of services.