Low Moor Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection visit on 12 February 2015 and the overall rating for the practice was good. The inspection team found after analysing all of the evidence the practice was safe, effective, caring, responsive and well led. It was also rated as good for providing services for all population groups.

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

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

We saw several areas of outstanding practice including:

- A paediatric consultant held a clinic once a month at the practice.
- There was a nurse led drop in blood clinic each Friday from 8am -10am.
- Every second Wednesday ultra sound scans were available at the practice, delivering care closer to patient's homes.
- A community pharmacist ran a fortnightly warfarin clinic.

Summary of findings

- The practice had a group of experienced volunteer 'Practice Health Champions', who work with their fellow patients to benefit their health and well-being. This is a Bradford CCG initiative.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. 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 saw staff treated patients with kindness and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population. It engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services, where these were identified. The practice had reviewed their appointments systems and made improvements. Patients said they found it easy to make an appointment and urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available on the website and it was easy to understand. Evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Summary of findings

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 and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. 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 outcomes for patients were good for conditions commonly found in older people. All patients over 75 years of age had a named GP. The practice offered proactive, personalised care to meet the needs of the older people in its population. It had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits. Regular visits to local nursing homes were also undertaken. Monthly multi-disciplinary meetings were held to review the care needs of older people. The practice worked closely with other health and social care organisations such as the community integrated care team. There were a number of in-house clinics where patients could obtain social care or benefits advice. Data showed the practice was a high achiever for flu immunisation for this group of patients.

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. All these patients had a named GP and a structured annual review to check their health and medication needs were being met. For those people with the most complex needs, the practice worked with relevant health and care professionals to monitor patient outcomes. They also participated in delivering a multidisciplinary package of care. We saw evidence of the practice team working with the most up to date guidance for diabetic patients, the nine points of care. An advanced nurse practitioner had been employed to support patients with complex needs. The practice held a number of in-house clinics to support this group of patients such as warfarin monitoring, and in house electrocardiogram (ECG) appointments. In addition the practice was participating in Bradford Healthy Heart initiative.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients. Once a month a Paediatric consultant held a clinic within the practice. There were systems in place to identify and follow up children who were at risk, for example, children and young patients who had a high number of accident & emergency (A&E) attendances. We were told children and young patients were treated

Summary of findings

in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice worked closely with other agencies such as the health visitors and support services for teenagers. We saw there was a number of in-house health and social care clinics.

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). It had identified and had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services. They had a full range of health promotion and appropriate screening for the needs of 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. They had an annual physical health check. They were offered longer appointments. Patients who required translation services were offered a longer appointment.

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

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

People experiencing poor mental health (including people with dementia)

Good

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

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and held in-house clinics. It had a system in place to follow up patients who had attended (A&E) who were known to have poor mental health.	

Summary of findings

What people who use the service say

We reviewed 27 CQC patient comments cards. All were very complimentary about the care and treatment they received. They had written how responsive the team were. They commented on the caring and considerate clinical team. We observed staff interaction with patients in the waiting area; we spoke with four patients and reviewed the report of the most recent patient survey. In summary patients were very positive about how the practice worked and met their needs**.** Two comment cards had identified they had difficulty getting through on the telephone to make an appointment.

- The practice's patient survey and the CQC comment cards showed patients were mostly content with the current appointment system. They felt they could access medical attention and advice when needed. Same day appointments or telephone consultations were available.
- Patients we spoke with said they would recommend the practice to other people. They felt listened to and involved in their treatment. It was evident patients felt all staff and doctors worked hard to ensure their healthcare needs were met.
- Patients knew they could speak to someone in private if necessary. They were aware of the chaperone facility offered when personal examinations were undertaken.
- All patients were happy with the cleanliness of the surgeries.
- The Patient Participation Group (PPG) was an active group. This was facilitated by the practice manager and one of the lead partners. It was evident the PPG was active and had contributed feedback about patients' views and in turn these had led to changes within the practice.

Outstanding practice

- A paediatric consultant held a clinic once a month in the practice.
- Nurse led drop in blood clinic each Friday from 8am -10am. Two healthcare assistants provide these clinics, patients we spoke with said how effective and helpful they have been. They told us the service was efficient and effective, they did not have to wait long at all to be seen.
- Every second Wednesday ultra sound scans were available at the practice, delivering care closer to patient's homes. We were told how helpful this was as it meant a shorter distance to travel and in familiar surroundings, helped to improve the patients' experience.
- A community pharmacist ran a fortnightly warfarin clinic for patients at the surgery. This too has meant improved patients experiences and immediate follow up where necessary.
- The practice had a group of experienced volunteer 'Practice Health Champions', who work with their fellow patients to benefit their health and well-being. These programmes were designed to enable patients with Long Term conditions to pro-actively improve their health. There are specific groups such as cancer support and relaxation. We also saw the healthy eating activities and the healthy walks programme. This is a Bradford CCG initiative and so some of the groups across the CCG work together at times.

Low Moor Medical 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 GP SPA and a practice manager SPA.

Background to Low Moor Medical Practice

Low Moor Medical Practice is located on the outskirts of Bradford. The building is purpose built and the practice moved in as tenants in 2005. There is good car parking facilities, with disabled access to the practice.

The practice is registered with the CQC to provide the following regulated activities: Maternity and midwifery services; Diagnostic and screening procedures; Treatment of disease, disorder or injury; and Surgical procedures. The practice provides Personal Medical Services (PMS) to 9,000 patients, under a contract with Bradford Districts Clinical Commissioning Group. PMS is a locally agreed alternative to General Medical Service (GMS) for providers of general practice. The area is less deprived than inner city Bradford however; it is more deprived than the national average.

There are four GP partners in the practice. In addition there are three salaried GPs one female and two males. The doctors are supported to deliver clinical care by an Advanced Nurse Practitioner, two practice nurses and two healthcare assistants. In addition there is a well-established administration team; they include a practice manager, an operations manager, medical secretaries, an administration team and a team of receptionists.

The practice is open each weekday from 8 am until 6pm apart from Mondays when there is a late night surgery until 8pm for people who work and cannot commit to appointments during the day. Patients can access the appointment system by telephone, presenting at reception or on line via the practice web site. Some appointments are pre-bookable and some are allocated to be booked on the day.

There is a drop-in blood test clinic each Friday from 8am until 10am, this service is run by the healthcare assistants. The telephone system goes to answer phone on Wednesday afternoons at 12 noon to facilitate staff training sessions. There are some urgent bookable appointments available on a Wednesday afternoon. Local Care Direct provides the Out of Hours service, from 6pm to 8am daily and each weekend and bank holidays.

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.

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 the CQC at that time.

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Detailed findings

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How we carried out this inspection

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

We carried out an announced visit on 12 February 2015. During our visit we spoke with a range of staff including GPs, practice nurses, health care assistant (HCA), two receptionists and the practice manager. We also spoke with four patients who used the practice including a member of the practice's Patient Participation Group (PPG).

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We reviewed 27 CQC patient comment cards where patients had shared their views and experiences of the practice. We also reviewed records relating to the management of the practice.

Information from the General Practice Outcome Standards (GPOS), Quality Outcomes Framework (QOF) and Bradford District CCG information showed the practice rated as a high 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 had systems in place to record, monitor and learn from incidents which had occurred within the practice. Safety was monitored using information from a range of sources. These included the Quality and Outcomes Framework (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.

Staff were able to give examples of the processes used to report, record and learn from incidents. They confirmed these were discussed in the regular practice meetings.

Learning and improvement from safety incidents

The Practice has a system in place for reporting, recording and monitoring significant events. The practice manager provided a summary of the four significant events which occurred in 2014. We also reviewed the significant events records at the practice. Significant events and complaints were a standing item on the practice meeting agenda. There was evidence the practice had learned from these and the findings were shared with relevant staff. For example, following an incident relating to a patient's over ordering of medicines, systems were changed within the practice. This system was to be re-audited again.

We saw records of incidents, investigation and actions taken. We saw where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken. We found from records action had been taken, following incidents, to safeguard patient's health and welfare where necessary. We saw where incidents had involved other organisations these had been communicated to the relevant department and action had been taken to minimise the risk of errors recurring.

Reliable safety systems and processes including safeguarding

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. Staff had received training relevant to their role and this included safeguarding vulnerable adults and children. We were told there was a CCG wide initiative being developed to ensure all vulnerable people are safeguarded using best practice guidelines. The lead GP (for safeguarding vulnerable adults and children) was involved with this work. They were trained to Level 3 and they informed us they had participated in local safeguarding meetings for their patients, when required. We saw 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 received instruction from the GP when involved in chaperoning. When chaperoning had taken place this was recorded in the patient's records.

Medicines management

The practice was supported by a pharmacist each week, which helped with prescribing audits to ensure patients received appropriate medicines. We saw the 2013/2014 prescribing audit report which identified the positive changes which had been undertaken within the practice. Such as the appropriate read coding of patients who attended the Rheumatology clinic and the Warfarin clinic. This assured they would have consistent and appropriate monitoring via regular blood tests, to maintain their health and well-being.

We saw the practice had begun to use the tool known as the Productive General Practice. This helped practices who used it to become more effective and efficient in their everyday work. We saw they were to make changes to their repeat prescribing in April 2015.

There were appropriately stocked medicine and equipment bags ready for doctors to take on home visits. However, we opened one of the supplied safety sealed emergency drugs packs and found out of date medicines. The system at the practice had been to check the expiry dates on the outside of the packs. We have since received the details of actions taken with the supplier and the actions/systems which will be undertaken in the practice to assure this does not occur again.

The GPs told us they received medicine alerts from the Clinical Commissioning Group (CCG), National Institute for

Good

Are services safe?

Health and Care Excellence (NICE) and Medicines Products Regulatory Agency (MHRA). We saw evidence of the meetings between the GP and the pharmacist and how these alerts were actioned and followed up. We were told where there had been changes to guidelines for some medicines, audits had been completed. Any changes in guidance about medicines were communicated to clinical staff in practice meetings.

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

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carried out staff training. All staff received induction training about infection control specific to their role and received annual updates. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. They were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury; staff we spoke with confirmed their understanding. We were shown the body fluids spillage kits, which were easily accessible. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice's landlord (for their building) had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). This information was shared with us.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly. We saw equipment maintenance logs and other records which confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometers.

Staffing and recruitment

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

We saw the locum pack to help support locums when first employed. Although we were told they were used rarely and they preferred to use locums who knew them.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure enough staff were on duty. There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there was always enough staff to maintain the smooth running of the practice and likewise always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate actual staffing levels, succession planning and the appropriate skill mix. We saw evidence of succession recruitment planning to help ensure there was sufficient staff to provide safe and effective care.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management,

Good

Are services safe?

staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. Arrangements were in place to protect patients and staff from harm in the event of a fire. This included staff designated as fire wardens who carried out appropriate fire equipment checks and held regular fire drills.

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 appointments were reserved each day for 'on the day' emergencies. We were told everyone was seen on the day who presented as an emergency.

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

We saw staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. There was evidence of learning from incidents and responding to risk had taken place and appropriate changes implemented. The practice 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.

Staff spoken with and records seen, confirmed 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. Such as power cuts and adverse weather conditions which may interrupt the smooth running of the service. The plans were accessible to all staff. The plan included an assessment of potential risks which may affect the day-to-day running of the practice. It provided information about contingency arrangements staff would follow in the event of an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients we spoke with told us they 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. The GPs and other clinical staff told us they had access to and followed NHS Bradford District CCG guidelines and care pathways for patients We saw patients treatment plans were reviewed in discussion with GPs and appropriate changes made where necessary. This was shared at the practice clinical meetings and multidisciplinary meetings.

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. 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.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. The GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and improvements to practice were shared with all clinical staff.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed the culture in the practice was patients were cared for and treated based on need. The practice took account of patient's age, gender, race and culture as appropriate.

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. This was used to monitor the quality of services provided. For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated care and treatment and documented the success of any changes.

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.

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, to improve patient's health outcomes.

We saw minutes of practice meetings where new guidelines were shared. 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 each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses they completed thorough assessments of patients' needs in line with NICE guidance, and these were reviewed when appropriate.

New patients were invited for a full health check; the GPs followed up any identified health needs. Clinics for patients with 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.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw all staff were up to date with mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with a number had additional interests in mental health, child and maternal health and surgery. All

Good

Are services effective?

(for example, treatment is effective)

GPs were up to date with their continuing professional development requirements and all either had 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 can the GP continue to practise and remain on the performers list with NHS England).

The Practice nurses were expected to perform defined duties and demonstrated they were trained to fulfil these duties. For example, administration of vaccines, cervical cytology. Those with extended roles e.g. seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were able to demonstrate they had appropriate training to fulfil these roles. All nurses had their 'fitness for practise' reviewed each year via the Nursing and Midwifery Council (NMC) and details of their registration was on the NMC web site.

All staff had annual appraisals where learning needs were identified and action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses, for example infection control.

Working with colleagues and other services

Staff we spoke with felt they were listened to and involved in the running of the practice. There were clear lines of accountability and staff understood their roles.

The practice used a computer system to store patient records. Staff input data such as discharge letters and blood results into the electronic records. Tasks were then sent electronically for the GP to review the information. In addition records for patients with complex needs were available to all professionals providing care, if prior patient consent had been given.

Staff told us they had regular meetings and were able to describe the content of the discussions in the meetings and any actions taken in response. The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The monthly pre-booked appointments for the paediatric clinic had improved access for children and their families/ carers. In addition it had consolidated working relationships between the GPs and the consultant. We saw evidence of working in a more streamlined way, when supporting children who required screening tests.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (Choose and Book 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.

We saw evidence of multi-disciplinary team meetings where patients with complex needs were discussed to help ensure their changing needs were documented and discussed.

Consent to care and treatment

We found clinical staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and they were able to describe how they implemented it in their practice. They also confirmed their understanding of capacity assessments and how these were an integral part of clinical practice. They 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 and included issues relating to capacity.

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 it was effective as it was available to them when needed.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if

Good

Are services effective?

(for example, treatment is effective)

changes in clinical circumstances dictated it) and they had a section which stated the patient's preferences for treatment and decisions. There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients who registered with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The system in place used the GP-GP transfer of information and was effective in raising awareness of medical problems very soon after patients registered with the practice. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental and physical health and wellbeing.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed patients in this age group were beginning to take up the offer of the health check. A GP showed us how patients were followed up immediately if they had risk factors for disease identified at the health check and how they scheduled further investigations.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 27 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We saw staff were careful to follow the practice's confidentiality policy when they discussed patients' treatments so confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, and satisfaction questionnaires sent out to patients. The evidence from these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. The practice was also above average for its satisfaction scores on consultations with nurses. Patients stated the GPs and the nurses listened to them and they said they always gave them enough time, when in consultation.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. We saw privacy curtains were provided in all consulting room so patients' privacy and dignity was maintained during examinations, investigations and treatments. There were clearly visible notices in the patient reception area and GP surgeries informing patients they could request a chaperone.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected; they would raise these with the practice manager. They were confident these concerns would be investigated.

There was a visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded to questions about their involvement in planning. This included making decisions about their care and treatment and generally rated the practice slightly lower than the national average in these areas. However, patients we spoke with on the day of our inspection told us health issues were discussed with them. They felt involved in decisions about the care and treatment they received. They also told us they felt listened to and supported by staff. They had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

There was evidence of care plans and patient involvement in agreeing them for older patients and those who had long-term conditions. We saw information was available about end of life planning.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it highly in this area. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with the survey information. For example, they highlighted how staff responded compassionately when patients/carers needed help and how they provided support when required.

Notices in the patient waiting room informed patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. We also saw the practice's 'Health Champion' volunteers who were available to signpost and encourage patients to access the groups they facilitated.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. 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.

We were told by the PPG representatives we met, how the appointment systems had been amended after the results of their patients survey had been shared. There were now on the day appointments available. In addition there was now a late night surgery every Monday. Lunchtime surgeries were now available. They found the surgeries were often running late. So to improve this problem a break was introduced after every fourth patient. The PPG intend to revisit these concerns to check patients experiences have improved in these areas.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and to prioritise service improvements.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Patients who were carers were flagged on the IT system so clinical staff could explore their health and social support needs. This was documented so future consultations would consistently follow up issues identified.

The patients had access to online and telephone translation services, where necessary.

The building which housed the practice was purpose built with most services for patients on the ground floor. There was lift access to the first floor. We saw the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed they had completed the equality and diversity training in the last 12 months and how equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

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

The practice was open each weekday from 8 am until 6pm apart from Mondays when there was a late night surgery until 8pm for people who work and cannot commit to appointments during the day. Patients can access the appointment system by telephone, presenting at reception or on line via the practice web site. Some appointments were pre-bookable and some were allocated to be booked on the day.

There was a drop-in blood test clinic each Friday from 8am until 10am; this service was run by the healthcare assistants. The telephone system goes to answer phone on Wednesday afternoons at 12 noon to facilitate staff training sessions. There were some urgent bookable appointments available on a Wednesday afternoon.

Longer appointments were available for patients who needed them and those with long-term conditions. Patients who required an annual or more frequent health review were contacted personally via the telephone. An appointment time convenient to the patient was then agreed. This had helped mitigate against non-attenders. This included appointments with a named GP or nurse. Home visits were made to local care homes each week. Home visits were available each week day to those patients who needed a home visit.

Patients were generally satisfied with the appointments system. They confirmed they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their

Good

Are services responsive to people's needs?

(for example, to feedback?)

choice. Comments received from patients showed patients in urgent need of treatment had often been able to make appointments on the same day they contacted the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. We saw evidence complaints had been responded to in a timely way and followed the practice policy.

The practice had received 10 complaints in the past 12 months; we saw they were responded to as per the practice policy. The practice manager told us all complaints were taken seriously. They had an open door policy for staff and patients so concerns or complaints could be responded to in a timely manner.

Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

Are services well-led?

Good

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

Our findings

Vision and strategy

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 and their needs came first. They wanted to deliver personal professional services to their patients.

Governance arrangements

There was a management structure with clear allocations of responsibilities. There were named leads which included safeguarding, prescribing and governance. Staff we spoke with were all clear about their own roles and responsibilities. They 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, action plans had been produced and implemented.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it performed in line with national standards. We saw QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

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 who met monthly and practice meetings were also held weekly.

Leadership, openness and transparency

We saw from minutes team meetings were held regularly. Staff told us there was an open culture within the practice and they had the opportunity to and were happy to raise issues at team meetings.

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 carer's resource team and mental health care workers.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, disciplinary procedures, performance improvement and grievance and disputes which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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. The staff felt they could raise concerns at any time with either the GPs or practice manager. They were considered to be approachable and responsive. The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

We saw actions had been taken following the patient participation group (PPG) survey feedback about the availability of on the day appointments. The results from the survey had also influenced the introduction of lunchtime clinics. In addition 'care closer to the patients' home' had commenced with fortnightly scanning clinics and monthly warfarin clinics. We found because of these new initiatives patients did not have to travel distances to the hospital for screening and treatment of their conditions.

Management lead through learning and improvement

We saw an induction programme was completed by new staff and 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. Staff told us the

Are services well-led?

Good

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

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. The practice had completed reviews of significant events and other incidents. These reviews were shared with staff at meetings and staff away days to help ensure the practice continued to provide improved outcomes for patients.