Spring Hall Medical Practice (Boots Branch)

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Spring Hall Medical Centre (Boots branch) on 3 March 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Information about safety was recorded.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment
- Information about services and how to complain was available and easy to understand.
- Urgent appointments were usually available on the day they were requested
- The practice had good facilities and was well equipped to treat patients and meet their needs
- There was good medicines management overall
- There was a clear leadership structure and staff felt supported by management

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. There were enough staff to keep patients safe. Staff understood their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated to support improvement. There were Health and Safety and Infection Prevention and Control policies in place. There were processes in place for safe medicines management.

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Patients who responded to CQC comment cards and those we spoke with during our inspection said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw staff treated patients with respect and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Calderdale Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had good facilities and was well equipped to treat patients and meet their needs. Urgent appointments were available on the same day and there was continuity of care. Information about how to complain was available both in the practice and on the website. 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 and staff were clear about their roles and responsibilities in relation to this. There was a clear leadership structure and staff felt supported and valued by management. The practice had a number of policies and procedures in place and held regular practice meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from patients and staff which it acted upon. Staff received induction, regular performance reviews and attended staff meetings.

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. The practice was responsive to the needs of older people, offering home visits and longer appointments. The practice used a holistic care approach for all patients aged over 75, where clinicians assessed their health and social care needs. The practice worked closely with other health care professionals and agencies such as the community matron, district nursing team and Staying Well Ageing Better project, which specifically targeted loneliness in the elderly.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The practice had a GP led approach to long term conditions, supported by the nursing team. There were structured annual reviews in place to check the health and medication needs of patients were being met. Longer appointments and home visits were available when needed. For those patients with the most complex needs, the named GP worked with other professionals to deliver a multidisciplinary package of care. The practice held scheduled clinics, such as diabetic clinics where a podiatrist was also available.

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. Appointments were available outside of school hours and the premises were suitable for children and babies. Same day appointments were offered for children 16 years of age and under.

The practice provided sexual health support and contraception, maternity services and childhood immunisations. A text messaging service was used to remind mothers of baby health check and immunisation appointments.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The practice had

Summary of findings

extended hours, including pre-bookable early morning appointments. It had a branch in the town centre which also opened Saturday mornings. Patients could attend either practice location to access appointments to meet their specific needs.

People whose circumstances may make them vulnerable

Good

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

The practice worked with multidisciplinary teams in the case management of vulnerable people, including persons who were of no fixed abode. Staff signposted patients to various support groups and services, such as drug and alcohol services.

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.

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. The practice offered annual health reviews, longer appointments and home visits as needed. The GPs actively screened patients for dementia and maintained a list of those diagnosed. The practice had a targeted focus on dementia screening and depression assessments and had identified significantly higher numbers than the predicted rate nationally.

There was a system in place to follow up patients who had attended accident and emergency (A&E) when they may have been experiencing poor mental health. Staff were aware of how to care for people with mental health needs and dementia. The practice regularly worked with multidisciplinary teams in the case management of people in this population group.

Summary of findings

What people who use the service say

We received 29 CQC patient comment cards and we spoke with five patients on the day of our inspection. We spoke with patients from different age groups, who had different physical and mental health needs and had varying levels of contact with the practice.

The comments from the CQC cards were complimentary about the care provided by staff, their friendliness and behaviour. The patients we spoke with said they were satisfied with the care and were encouraged to see the same GP for an on-going health condition. They said they felt listened to and were treated with dignity and respect.

The majority of patients were complimentary about the appointment system, its ease of access and the flexibility it provided. All the patients we spoke with on the day had received an appointment of their choice and with the clinician they wanted to see.

Patients said the practice was always clean and tidy.

Spring Hall Medical Practice (Boots Branch)

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 and a practice manager specialist advisor.

Background to Spring Hall Medical Practice (Boots Branch)

Spring Hall Medical Practice (Boots branch) is registered with CQC to provide primary care services, which includes access to GPs, family planning, surgical procedures, treatment of disease, disorder or injury and diagnostic and screening procedures. The practice is part of Calderdale CCG and responsible for providing primary medical services for approximately 8800 patients under a primary medical services (PMS) contract with NHS England.

The practice is a branch surgery based within Boots in the town centre which has no dedicated parking facilities. It's main surgery is approximately two miles from the centre of Halifax on Spring Hall Lane which has good parking facilities. Both locations were visited as part of this inspection.

The two sites have a single patient list, so patients could be seen at either practice depending on which was more convenient for them. The practice had seven GP partners (two male and five female). The nursing team included two practice nurses and two health care assistants. There was an experienced team of management, administration and reception staff. All clinical and reception staff rotated between the two locations.

The Boots branch was open 8am to 6.30pm Monday to Friday and 9am to 12pm on a Saturday. Spring Hall Lane surgery was open from 8am to 7.15pm on Monday and 8am to 6.30pm Tuesday to Friday. Patients could book appointments in person at both locations or by telephone. Some appointments are pre-bookable and others are bookable on the day. The practice also operates a daily telephone triage system where patients can speak to the duty doctor. Out of hours care is provided by Local Care Direct service.

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

Before our inspection we carried out an analysis of the data from our intelligent monitoring system. We also reviewed information we held and asked other organisations to share what they knew about the service.

We carried out an announced inspection visit on the 3 March 2015. We visited the branch surgery which is situated within Boots, 7-11 Market Street, Woolshops, Halifax HX1 1PB and the main surgery at Spring Hall Medical Centre, Spring Hall Lane, Halifax HX1 4JG.

During our visit we spoke with a range of staff, including a GP, the practice manager, a practice nurse and two administration/reception staff. We also spoke with five patients who used the service. We reviewed 29 CQC patient comment cards where patients had shared their views and experiences of the practice.

We observed communication and interactions between staff and patients; both face to face and on the telephone within the reception area. We also reviewed records relating to the management of the practice.

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

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

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

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

People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included reported incidents, national patient safety alerts, clinical audits, comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. We reviewed safety records, incident reports and saw evidence in minutes of clinical meetings where these were discussed. This demonstrated the practice had managed incidents consistently over a period of time.

Learning and improvement from safety incidents

The practice had systems in place for reporting, recording and monitoring significant events, incidents and accidents. These included sending a task to the practice manager who then raised them as a agenda item to be discussed at practice meetings. Staff told us they were aware of what incidents had taken place, actions taken by the practice and learning from these events.

The practice manager showed us the system they used to manage and monitor incidents and we looked at records of reported incidents covering the last twelve months. We saw evidence the practice had managed these consistently.

Staff told us they felt confident in raising issues with the GPs and management team. They were encouraged to report any incidents and said the practice had a 'no blame' culture.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had a designated GP lead in safeguarding vulnerable adults and children, who was also the clinical safeguarding lead for the CCG. We were told all safeguarding incidents were reported to the lead, or a deputy in their absence. At the time of our inspection we were shown an example of a recent clinical safeguarding issue and the process the practice had undertaken.

We looked at training records which showed all clinical and non-clinical staff had received safeguarding training to level 3. Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, record safeguarding concerns and how to contact the relevant agencies. Safeguarding policies and procedures and the contact details of relevant agencies were available and easily accessible for all staff. We were shown the shortcut on the computer system where staff could easily access safeguarding contact details and reporting mechanisms.

A system was in place to highlight vulnerable patients on the practice's electronic record, for example looked after children (LAC) and children in need. We were shown an example regarding a 'team around the child' (TAC) and how it was recorded and flagged on the computer system. The practice held monthly multidisciplinary meetings to discuss concerns and share information about children and vulnerable patients registered at the practice.

There was a chaperone policy in place although we noted this had not been reviewed since 2009. There was information in the practice which advised patients of the availability of a chaperone if requested. Reception staff had been trained as part of their induction programme.

Medicines management

The practice employed a pharmacist who gave advice on safe, effective prescribing of medication. This included the checking and advising on repeat prescribing and medication reviews. The pharmacist was also responsible for medicines reconciliation (updating medication information in patients' electronic records in response to any changes made by secondary care). They also contacted the patient to discuss the changes and dealt with any queries relating to medication.

Requests for repeat prescriptions were taken by post, over the internet and in person at reception. In order to minimise risk, ordering over the telephone was not encouraged. We were informed by staff patients' medication was reviewed every six to twelve months, or more often depending on their individual condition. We were shown an electronic audit trail of a review undertaken and the actions taken, which had resulted in a change of medication. We were also shown prescribing audits and any actions the practice had undertaken.

Good

Are services safe?

We saw equipment and medicines for use in emergency were accessible for staff and in date. Nursing staff told us they were routinely checked and we saw records to corroborate this.

Vaccines were stored in locked refrigerators. We were told the procedure was to check the temperatures twice a day, at 8.30am and 6.30pm. We saw evidence of daily records being kept which were dated, had the temperature recorded and signed. We were told vaccines were checked for expiry dates on a monthly basis and disposed of in line with the practice protocol. The selection of vaccines we looked at were all in date.

We were informed that doctors are responsible for checking their own bags. Upon checking one of the doctor's bag, we found out of date water for injection, needles and syringes. The practice informed us they would dispose of these and replace them.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness or infection control. We were told Boots was responsible for cleaning of the premises. The practice would alert Boots if there were any issues regarding cleanliness.

The practice had a clinical lead for infection prevention and control (IPC), who had been suitably trained. There was an IPC policy in place, which included management of needle stick injuries. Personal protective equipment, which included disposable gloves and aprons, were available for staff to use. Hand washing sinks, antibacterial gel and hand towel dispensers were available in treatment rooms. Sharps bins were appropriately located and labelled. The practice had access to spillage kits to enable staff to deal with any spillage of body fluids. All staff received induction training about IPC specific to their role. Staff we spoke with were aware of the procedures in place to prevent cross infection and what to do in an incident.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments, treatments and emergencies. They told us all equipment was tested and maintained regularly and we saw records which confirmed this.

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

Staffing and recruitment

The practice had a recruitment policy, which set out the standards it followed when they recruited clinical and non-clinical staff. We looked at a sample of personnel files for the most recently employed clinical and non-clinical staff and saw appropriate recruitment checks had been undertaken. For example, appropriate qualifications for the role, references and criminal record checks through the Disclosure and Barring Service (DBS). The practice routinely checked the professional status of the GPs and practice nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) registers. All staff received an induction and there was a policy and checklist in place, which was kept in the staff member's file upon completion. We saw evidence of this.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet the needs of patients. There was an arrangement in place for members of staff to cover each other's annual leave and sickness. We were told staff either worked mornings or afternoons, which allowed flexibility in how they would cover a shift, should an urgent need arise. There was a rota system for staff to work across both locations.

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. We were shown the panic alarm system available on the computer system. Staff we spoke with knew the location of fire equipment and how to use it.

There was evidence of learning from incidents, responding to risks that had taken place and appropriate changes implemented. These were discussed at clinical, practice and other relevant meetings. The practice also reported to external bodies such as Calderdale Clinical Commissioning Group (CCG), the local authority and NHS England in a timely manner.

Arrangements to deal with emergencies and major incidents

Good

Are services safe?

A business continuity plan was in place to deal with a range of emergencies which may impact on the daily operation of the practice. Risks identified included loss of access to the building, power failure, incapacity of staff, epidemic/ pandemic and response to a major incident. The document was available electronically and as a hard copy. The practice manager told us they also had a hard copy available at home.

We saw evidence all staff had been trained in Basic Life Support and this was updated on an annual basis. There was emergency equipment available for use, which included a defibrillator and oxygen. All the staff we spoke with knew where it was kept and how it should be used. Emergency medicines were available for use in the treatment of cardiac arrest, anaphylaxis and hypoglycaemia and staff knew their location.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with best practice guidance. They accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told any updates were circulated and discussed at practice meetings as appropriate. We were also informed the practice had a shared drive on the computer system, where the latest guidelines and protocols were available for staff. We found from our discussions with the clinical staff how they completed thorough assessments of patients' needs in line with NICE guidance and these were reviewed when appropriate.

We were informed GPs each had a lead in specialist clinical areas such as diabetes, respiratory, cardiology and dermatology. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. One doctor told us how they mentored a nurse through training in diabetes treatments. We were shown data from the CCG of the practice's performance for antibiotic prescribing, which was comparable to other local practices.

The practice had registers for patients with long term conditions, including palliative care. This supported patients to have their conditions reviewed and monitored using standardised local and national guidelines. The nursing staff we spoke with told us they used personalised self care management plans with patients as appropriate, raised awareness of health promotion and referred/ signposted to other services when required. A clinician showed us an electronic template the practice used which identified patients who were eligible for referral to obesity services, using local guidelines.

There were systems in place to identify and monitor the health of vulnerable groups of patients. We were told patients who had learning disabilities were given longer appointments, annual reviews were undertaken and consent documented.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits and other improvements to the service.

Clinical audit, clinical supervision and staff meetings were used to assess performance. The practice had a system in place for completing audit cycles. We were shown examples of clinical audits such as dyspepsia (gastro-oesophageal reflux disease) and the use of antibiotic prophylaxis in splenectomy patients. Following each clinical audit, changes to treatment or care were made where needed and the audit to be repeated to ensure outcomes for patients had improved.

Information collected for the Quality and Outcome Framework (QOF) and performance against national screening programmes was also used to monitor outcomes for patients. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.) The practice met all the minimum standards for QOF in diabetes, asthma, COPD and mental health and were above average in other areas, compared across the CCG, particularly in dementia, depression, epilepsy and learning disabilities. The practice had a targeted focus on dementia screening and depression assessments and had identified significantly higher numbers than the predicted rate nationally (116% dementia and 96.15% depression assessment, Primary Care Web Tool).

The practice had a palliative care register and held regular multidisciplinary team meetings to discuss the care and support of patients.

Effective staffing

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

GPs were up to date with their continuing professional development requirements and all have either been revalidated or had a date for revalidation. (Every GP is

Are services effective?

(for example, treatment is effective)

appraised annually and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council (GMC) can the GP continue to practise and remain on the performers list with NHS England.)

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

The clinical and non clinical staff confirmed they had annual appraisals. They told us it was an opportunity to discuss their performance and any appropriate training they either needed or wanted to attend. A nurse told us they had been supported through the nurse prescribing course, which had been identified as part of their personal development plan (PDP). All the staff we spoke with felt they were well supported in their role and confident in raising issues with the practice manager or GPs.

The most recently employed staff told us about the induction programme they had undertaken and how they had been supported through the first few weeks of working in the practice.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those patients with complex needs. Procedures were in place to manage information from other services, such as hospitals and out of hours services (OOHs). Staff were aware of their responsibilities when processing discharge letters and test results. There were systems in place for these to be reviewed and acted upon where necessary by clinical staff.

The practice held monthly multi-disciplinary team (MDT) meetings to discuss the needs of palliative care patients. These meetings were attended by palliative care nurses and members of the district nursing team. In addition, other regular clinical meetings took place to discuss complex cases which included safeguarding. We saw minutes of some of these meetings.

The practice told us they had established a good working relationship with a local residential care home. The majority of residents were registered with the practice and they operated a weekly GP led clinic at the home, where residents could be seen and assessed as appropriate. There was access to the electronic patient records to allow for 'live' information. We were shown clinic protocols and minutes of meetings held between the practice and the care home.

Information sharing

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

Electronic systems were in place for making referrals and, in consultation with the patients, these could be done through the Choose and Book system. (The Choose and Book system is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.)

Information regarding consent for data sharing was available in reception and also via the practice leaflet and the website.

Consent to care and treatment

We found the clinicians were aware of the Mental Capacity Act 2005 and Children Acts 1989 and 2004 and were able to describe how they implemented it in their practice. All the clinical staff we spoke with understood the key parts of the legislation and confirmed their understanding of capacity assessments. Clinicians were able to give examples where consent for care and treatment had been discussed and mental capacity had been assessed. We were shown the electronic template the practice used and an example of how the mental capacity assessment had been recorded in a patient's electronic record.

Clinical staff we spoke with demonstrated a clear understanding of Gillick competency and Fraser guidelines. These are used to assess whether a child under 16 has the maturity and understanding to make their own decisions and give consent to treatments being proposed.

Health promotion and prevention

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children, flu vaccinations and travel vaccinations in line with current national guidance. Data showed the practice performance for all immunisations was average for the local CCG.

The practice offered cervical cytology screening. Patients were sent for centrally and the practice proactively followed up non-attendance and recalls. The practice's performance for cervical cytology screening uptake was 81.4% which was similar to other practices in the CCG area.

The practice provided 24 hour blood pressure monitoring, electrocardiogram (ECG) services and ultrasound services to support a more timely diagnosis for patients.

The clinical staff told us how they promoted healthy lifestyles with patients and referred or signposted to other services. The practice participated in the weight management voucher schemes. Smoking cessation advice was delivered by nursing staff. Health advice was given via a telephone triage system as and when required. There was evidence of health promotion literature available in the clinical rooms and also in the reception area. The practice website also provided health promotion and ill health prevention advice.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed reception staff were courteous, spoke respectfully to patients and were careful to follow the practice's confidentiality policy.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation/treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. Staff told us if they had any concerns or observed any instances of discriminatory behaviour, or where a patient's privacy and dignity was not being respected, they would raise these concerns with the practice manager. There was a visible notice in the reception area, in the practice leaflet and on the website, stating the practice's zero tolerance for abusive behaviour.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey (January 2015), where from 438 surveys, 121 (28%) responses were received. Eighty five per cent of these respondents said the doctor they saw treated them with care and concern. This was in line with the average of the local CCG.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 29 completed cards which were positive about the service they experienced. We also spoke with five patients on the day of our inspection who all told us they were satisfied with the care they received and staff treated them with dignity and respect.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice good in these areas. For example, data from the national patient survey showed 84% of respondents said the GP involved them in care decisions and was good at explaining treatment and results.

The patients we spoke with also told us health issues were discussed with them in a way they could understand. They felt involved in decision making about their care and treatment. They told us they felt listened to and had enough time during a consultation to make an informed decision about the choice of treatment they wished to received.

Clinical staff told us written care plans were undertaken in conjunction with patients who had a long term condition. An example was shown to us using the NHS 'Year of Care' approach with patients who had diabetes. This is a proactive personalised care approach which supports improved patient involvement and self management. Care plans were also used for care home residents who were registered with the practice.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of the inspection told us staff were caring and provided support when required. Some of the comments on the CQC comment cards also reflected this. There was information available in the practice and also on the website offering counselling services and advising patients/carers what to do in a bereavement.

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 patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice told us they engaged regularly with the local CCG and other agencies to discuss the needs of patients and service improvements. The practice sought the views of patients through the Patient Participation Group (PPG) and the friend and family test. We were shown a recent example where the practice had taken action in response to the PPG's recommendations.

The practice provided a service for all age and population groups. Longer GP and nurse appointments were made for those who needed them, for example people with learning disabilities or long term conditions.

Tackling inequity and promoting equality

The practice had recognised the needs of the different population groups in how they planned services. For example, the practice had systems in place which alerted staff to patients with specific needs or who may be at risk. The practice responded to the needs of the patients who were registered in a local residential care home and attended on a weekly basis.

There was good disabled access to the building and all patients areas and consulting rooms were on the ground floor. The patient areas were sufficiently spacious for wheelchair and pram access.

Staff told us they had access to translation services during consultations using language line (a telephone based system) for patients who did not have English as a first language. We were also informed that some reception staff were Polish speaking and could translate information for patients where applicable.

Access to the service

Data from the national GP patient survey showed 78% (CCG average 73%) of respondents found it easy to get through to the practice by telephone and 98% (CCG average 92%) said the last appointment they got was convenient. The majority of patients we spoke with said they found it easy to get an appointment but had to wait longer to see a GP of their choice.

Information regarding the practice opening times and how to make appointments was available in the reception area, in the practice leaflet and website. Appointments were pre-bookable either by telephone or in person at the reception. There were urgent same day appointments available. Patients could access both practice locations for an appointment which was convenient for them. All the patients we spoke with on the day of the inspection had telephoned that morning and received an appointment the same day.

The practice also operated a daily telephone triage system where patients would speak with the duty doctor for advice and support. These could be booked via reception, telephone or online via the practice website. We were informed patients could be telephoned back at a time which was suitable for them, taking into account working or school hours. There were several comments on the CQC comment cards praising the telephone triage service. Nursing staff told us they would often fit additional patients in their clinics as the need arose.

A text messaging service was used to remind patients (who had consented to receive them) 24 hours prior to their appointment. Home visits were offered for patients who found it difficult to access the surgery.

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

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice, there was also a designated deputy in their absence.

We saw information was available to help patients understand the complaints system both in the reception area and on the practice website. We were shown a complaints form which we were told was completed at the

Are services responsive to people's needs?

(for example, to feedback?)

time of a complaint being made. Not all of the patients we spoke with were aware of how to make a complaint but they told us they hadn't needed to make a complaint about the practice.

We looked at how complaints received by the practice in the last twelve months had been managed. The records showed the complaints had been dealt with in line with the practice policy. It wasn't clear whether patients had been given information on how to escalate their complaint if they were not satisfied with the response. Staff told us complaints were discussed at meetings and we saw minutes from meetings evidenced this.

Are services well-led?

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients, details could be found in the reception area and on the practice website. The practice vision and values included ensuring safe effective services, which were accessible to all patients and delivered by staff who would treat patients with dignity, respect and honesty.

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

Governance arrangements

The practice had a number of policies and procedures in place to govern activities and these were available to staff via the desktop on the computer system. We looked at several policies and found some of them were not dated nor had a review date. For example, the complaints policy and significant event policy.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out and actions implemented. For example, we saw a fire risk assessment had been completed, fire alarms tested and staff received regular fire safety training.

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

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

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

We found the management team and staff continually looked to improve the services being offered. We looked at minutes from the last two practice meetings and found performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes team meetings were held monthly and clinical meetings were held on a weekly basis. Staff told us there was an open culture within the practice and all members of the management team were approachable, supportive and appreciative of their work.

The practice was committed to continuing education, learning and development of staff. A practice nurse told us about recent learning and development they had been supported to attend.

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

The practice had an active Patient Participation Group (PPG) of approximately 48 members from various population groups, which was supported by the practice. The group had identified various issues for the practice to improve and we saw evidence where actions had been taken. For example the PPG had commented the reception had been 'dark and dingy', whereupon the practice improved the lighting in that area.

The practice had gathered feedback from staff through meetings, appraisals and discussions. Staff told us they felt comfortable in giving feedback or raising any concerns. They felt involved and engaged in the practice to improve outcomes for both patients and staff.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us annual appraisals took place, which included a personal development plan. This was evidenced in the staff files we looked at.

Are services well-led?

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

The practice had completed reviews of significant events and other incidents and shared the information at staff meetings to ensure the practice improved outcomes for patients. We saw evidence of this in minutes of meetings and logs of events.