Picton Medical Centre

Quality Report

Westbourne Green Community Health Centre
50 Heaton Road
Bradford
West Yorkshire
BD8 8RA
Tel: 01274 202500
Website: www.pictonmedicalcentre.nhs.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Picton Medical Centre on 3 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the older people, people with long-term conditions, working age people, families, children and young people, vulnerable people and people experiencing poor mental health.

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 a named GP with urgent appointments available the same day.
- 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 areas of outstanding practice:

- Patients experiencing long term mental health problems were given additional support to refer themselves to the local Improving Access to Psychological Therapies (IAPT) service, including arrangements to meet with IAPT staff within the practice premises.

Summary of findings

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. The practice used learning from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. 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 roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. Staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments 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

Summary of findings

was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from incidents, patient feedback and complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

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 as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk. There was close working with health visitors, midwives and school nurses. Immunisation rates were high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with local children's organisations, midwives, health visitors and school nurses.

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 needs of the working age population, those recently retired and students had been identified and the practice 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 as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

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 who were housebound or who had a learning disability. It carried out annual health checks for people with a learning disability and offered longer appointments.

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

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 worked with multi-disciplinary teams in the case management of people experiencing poor mental health. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Support was available with self-referral access to psychological therapies. The practice worked with a local south Asian community health service to provide counselling, employment and social support.

Summary of findings

What people who use the service say

During of our visit we spoke with three patients. They all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. We also received 38 completed CQC comment cards. The majority of the comment cards were very complimentary about the staff and the service they experienced. Patients said they felt the practice offered an excellent service and staff were helpful and caring. They said they were treated with dignity and respect. Two comments were less positive but there were no common themes to these. One was in relation to a delay in obtaining an appointment and the other about not being put at ease when speaking to their GP.

We reviewed the most recent data available from the national patient survey (January 2015) on patient satisfaction. Out of the 449 surveys sent out to patients a total of 54 (12%) had been returned. The results showed that 85% said they usually got to see or speak to their preferred GP (CCG average 42%) and 77% said they would recommend the surgery to someone new to the area (CCG average 59%).

In response to other questions the practice was rated at similar levels to the average for the CCG area. For example; 91% had confidence and trust in the last GP they saw, 86% said the last appointment they had was convenient and 71% were satisfied with the practice opening times.

Outstanding practice

- Patients experiencing long term mental health problems were given additional support to access Improving Access to Psychological Therapies (IAPT) services, including meeting with IAPT staff within the practice premises.

Picton Medical Centre

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 and specialist advisor with experience of GP practice management.

Background to Picton Medical Centre

Picton Medical Centre is located in a purpose build community health centre approximately one and a half miles from Bradford City Centre. The practice provides primary medical care services for approximately 5300 patients under the terms of a NHS Personal Medical Services contract. The practice list is open to patients who live in BD1, BD8, BD9 and some parts of the BD15, BD18 and BD2 postal areas in the West Bowling, Manningham and Girlington areas of Bradford.

The practice catchment area is within the 10% most deprived areas in England. There are a higher proportion of patients aged under 18 years (35%) and a lower proportion of patients aged over 65 years (5%) compared to the averages (21% and 16% respectively) for all GP practices in England.

Data compiled by Public Health England indicates that levels of income deprivation affecting children (41%) and older people (67%) are significantly higher than the England averages (22% and 18% respectively).

The population areas covered by the practice have a long history of immigration. The local population has traditionally included a mix of Asian, white and black populations but in more recent times has seen an influx of Eastern European settlers, asylum seekers and refugees. The high density of housing and multiple occupancy promote the spread of communicable diseases and contribute to the poor health status of the population. Many patients arrive with little or no experience of health care and no recorded medical history. Language and literacy skills are often limited and compliance with treatments is poor, with consequent increased demand on clinical time.

There are two permanent male doctors at the practice. They are supported by two advanced practitioners, a practice nursing team and an experienced administrative team. The practice is open from 7.00am until 6.00pm on Mondays, Thursdays and Fridays and from 8.00am to 6.00pm on Tuesdays and Wednesdays. Between 1 November 2014 and 31 March 2015, as part of the NHS winter pressures initiative, the practice opened from 9.00am to 11.30am on Saturday mornings. The results of the most recent (January 2015) GP national patient survey indicate very high levels of satisfaction with the staff and availability of appointments.

Specialist clinics are provided for Asthma, Cancer Care, Child Health Surveillance, Chronic Airways Disease, Coronary Heart Disease, Diabetes, Epilepsy, Hypertension, Learning Disabilities, Mental Health and Minor Surgery. Out of hours care is provided by Local Care Direct.

The practice is registered to provide; diagnostic and screening procedures, maternity and midwifery services, surgical procedures and the treatment of disease, disorder or injury from Westbourne Green Community Health Centre, 50 Heaton Road, Bradford, West Yorkshire, BD8 8RA.

Detailed findings

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.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 3 February 2015. During our visit we spoke with the GPs, nurses, managers and receptionists. We also spoke with patients who used the service. 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 information from a range of sources to identify risks and improve patient safety. These included; reported incidents, safety alerts, prescribing data, clinical audits, risk assessments and complaints. Minutes of practice meetings showed information about safety was regularly discussed and where appropriate action taken to maintain patients safety. There was also evidence that learning from events and incidents was shared with clinical and non-clinical staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events and incidents. Staff were aware of their responsibilities to raise concerns. They knew how to report incidents and near misses and felt encouraged to do so. Significant events and incidents were regular items discussed at practice meetings. There were systems to review the effectiveness of any improvement actions and if necessary reopen the incident for further consideration. National patient safety alerts received by the practice manager were checked for relevance and where appropriate circulated to a member of staff for action. There were procedures in place to check that the required actions had been carried out.

Reliable safety systems and processes including safeguarding

The practice had systems to identify, manage and review risks to vulnerable children, young people and adults. The practice had appointed a named GP as the lead for safeguarding. They had received the necessary training to enable them to fulfil the role, including level 3 safeguarding children training as recommended by the Royal College of Paediatrics and Child Health. Other staff had received relevant role specific training on safeguarding. All staff we spoke with were aware who the practice safeguarding lead was and who else to speak with in the practice if they had a safeguarding concern. They knew how to recognise signs of abuse, how to share information, properly record and document safeguarding concerns.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Minutes of multidisciplinary meetings showed that the practice had systems to review and manage safeguarding concerns. The practice had recently used a self-assessment tool to audit safeguarding arrangements. Assessments were made of; practice policies and procedures, staff training, patient records and patient information. The findings were used to further develop safeguarding arrangements and protect vulnerable patients.

Information about the practice's chaperone policy was displayed in the waiting area and consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff appointed to act as chaperones had received appropriate training. They understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

One of the GPs had been nominated as the lead clinician for prescribing within the practice. The practice had recruited an advanced nurse practitioner, who was also a qualified pharmacist, to provided additional support and guidance. Prescribing data was monitored, regular audits were carried out and discussed at practice meetings.

Medicines stored in the treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. Procedures were in place to check medicines were within their expiry date and suitable for use. There were procedures describing arrangements for the storage of vaccines and the action to take in the event of a potential failure of the cold chain. Expired and unwanted medicines were disposed of in line with waste regulations.

Policies and procedures were in place governing repeat prescribing, including misuse of medication. Clinical audit was used to evaluate the effectiveness of prescribing and identify improvements in clinical practice. Minutes of practice clinical meetings showed learning from prescribing audits was shared to improve patient care. Staff utilised the practice clinical system to identify patients with allergies or who were prescribed high risk medication.

Prescriptions were reviewed and signed by a GP or where appropriate by an advanced nurse practitioner before issue

to the patient. Procedures were also in place for the authorisation and electronic transfer of prescriptions (ETP). ETP is an electronic prescription service enabling prescription requests for most medicines to be sent electronically directly to the pharmacy chosen by the patient, removing the need to print and send a paper prescription. Blank prescription forms were handled in accordance with national guidance and kept securely at all times. The practice should note that security of prescriptions could be further improved by recording the serial numbers of boxed blank prescriptions at the time they are received by the practice.

Cleanliness and infection control

The practice premises were visibly clean and tidy. Patients we spoke with told us they found the practice clean and had no concerns about cleanliness. The practice had put in place an infection control policy and procedures. A named member of staff was nominated to act as the lead for infection control. Staff had received appropriate infection prevention and control training and could give examples of how they reduced the risk of infection, for example when accepting test samples or cleaning spillages.

Single use surgical equipment, personal protective clothing (gloves and aprons) and hand washing materials were available for staff to use. Staff had received specific training in hand washing techniques. Waste bins were provided for the separation of waste, including sharps.

The practice occupied premises within a community health centre. Routine cleaning was carried out by cleaning staff employed by the managing leaseholder. Cleaning equipment and cleaning schedules were provided for the cleaners to use. However, the practice was proactive in monitoring the standards of cleaning and had raised a number of concerns with the leaseholder. There were arrangements to audit the effectiveness of infection control arrangements. The most recent audit was completed in November 2014. Specific improvement actions had been identified, for example replacement of some chairs and waste bins, and implemented.

Equipment

Staff were provided with the equipment they needed to carry out diagnostic examinations, assessments and treatments. There were arrangements for the annual testing and maintenance of equipment, including the safety of portable electrical equipment. Maintenance and calibration records were kept for clinical and emergency equipment.

Staffing and recruitment

The practice had established policies and procedures which set out the standards it followed when recruiting staff. Staff records contained evidence that 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).

There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. A staffing rota was in pace and monitored to ensure there were sufficient staff on duty at all times, including arrangements in place to cover annual leave.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included a system of monthly and annual checks of the building, the working environment, management of medicines, infection control and emergency equipment. Information about health and safety was available on the practice IT network for staff to refer to. The practice manager was the nominated lead for health and safety matters. There were systems to identify and mange risks. Identified risks were recorded in a log which was regularly reviewed and used to prepare an annual risk report.

Staff were aware of the importance of identifying patients who may be at risk, for example because of a chaotic lifestyle, and ensuring concerns were referred to the practice manager. There were systems to identify patients who were carers. There were systems to identify and recall patients who had failed to attend appointments.

The practice participated in an enhanced service to manage patients who were at high risk of hospital admission. One member of the clinical team had been appointed to act as the lead for the service. A dedicated telephone line had been made available for high risk

Good

Are services safe?

patients to access the surgery and obtain support. Information about patients receiving palliative care was shared with out of hours services to ensure they were aware of potential risks.

Risk stratification tools were also used to assess vulnerable patients. The risk scores were reviewed by members of the clinical team and where appropriate care plans put in place. We discussed examples where the risk tool had been used to develop plans for; an acutely ill child, a mother with mental health concerns and a patient on repeat medication. The practice had successfully supported a patient who had previously experienced difficulties in appropriately accessing health care services. A member of staff telephoned the patient every weekday to ask how they were and offered reassurance.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff knew how to access and use this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Procedures were also in place to check whether emergency medicines were within their expiry date and suitable for use.

A business continuity plan was in place to deal with emergency situations that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and loss of access to the building. The plan also contained relevant contact details for contractors and businesses who provided emergency repair services. For example, contact details of a heating company to contact if the heating system failed. The practice had carried out a fire risk assessment. Named staff had been appointed as fire safety officers and had responsibility for checking fire safety equipment. Records showed that staff had received fire safety training and had practised fire evacuation drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff all had specialist lead roles, for example; prescribing, safeguarding, diabetes management or immunisations. Minutes of practice meetings indicated that staff were open about asking for and providing colleagues with advice and support. Clinical staff could outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE). For example, we saw minutes of practice meetings where guidelines on the treatment of diabetes had been discussed with the practice nursing team. The meeting also reviewed the performance of the diabetes clinic and areas which needed to be improved.

The practice used computerised tools to identify patients with complex needs and who had multidisciplinary care plans documented in their case notes. Automated alerts had been set up to remind GPs about patients who were due for their next 12 week review. The practice had also completed case note reviews of patients who had had an unplanned admission to hospital and new procedures were being implemented to assess the frailty of patients.

Patients experiencing mental health problems were offered annual reviews and where appropriate assistance to access support from local Improving Access to Psychological Therapies (IAPT) service. The practice had worked with the IAPT service to offer facilities to see patients within the practice. This was particularly beneficial for patients who were reluctant to be seen in an IAPT environment, worried about the stigma attached to mental health or because they felt safer in a familiar environment. The practice also encourage IAPT representation at integrated care meetings where patients with complex mental health needs were discussed.

National data showed that the practice was performing better than average in a number of areas, including; prescribing of anti-inflammatory medicines and antibiotics, registers of patients requiring additional support, at risk patients immunised against influenza and annual reviews of patients with dementia.

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

Management, monitoring and improving outcomes for people

All staff within the practice had roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was used to support the practice to carry out clinical audits.

The practice showed us four clinical audits that had been undertaken in the last six months. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit, for example a reduction in the number of patients with dementia taking anti-psychotic medication. Other examples included audits to assess the effectiveness of regular blood monitoring of patients on disease modifying anti-rheumatic medicines (also known as DMARDs).

Weekly clinical meetings held at the practice were used to discuss patient referrals and the use of national and local clinical guidelines. Learning from training events and local ASPIRE meetings (Action to Support Practices Implementing Research Evidence) was also discussed to promote improvements in evidence based medicine. The practice also used these meetings to review updates to the local NHS Acute Trust's electronic advice service (BAtPCT). This system was designed to help GPs to use new technology to obtain specialist opinion about the management of specific patients in certain clinical circumstances.

Information collected for the Quality Outcomes Framework (QOF) was 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. National data for 2013-2014 showed that the practice had achieved 99.6% of the available points and was above the CCG and England average for all 20 Clinical Domain indicators and seven out of the eight Public Health Domain indicators.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

The practice team included medical, nursing, managerial and administrative staff. The nursing team included practice nurses, advanced nurse practitioners and healthcare assistants. The healthcare assistants had previously been employed in administrative roles but had been supported to develop their clinical skills. An external training provider had been engaged to coordinate and deliver role specific training programmes and identified development needs. Staff training records were comprehensive, including dates of completed, scheduled and refresher training. The GPs were up to date with their yearly continuing professional development requirements and had either been revalidated or had a date for revalidation. (Every GP was appraised annually, and undertook a fuller assessment called revalidation every five years. Only when revalidation had been confirmed by the General Medical Council could the GP continue to practise and remain on the performers list with NHS England).

Human resources policies and procedures were in place to support recruitment, induction, staff development and performance management. There was a staff annual appraisal programme, however, because of sickness absence some staff were overdue an appraisal review. The practice manager was aware of the issue and had plans to resolve the situation. Staff spoke positively about the practice, the support they received the good team working.

The practice supported third year university medical students gain practical experience of primary care. The University's most recent annual report of the support provided by the practice (2013/14) included many examples of very complimentary feedback given by the students.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. One of the GPs had been nominated as the lead member of staff for information governance. Other staff had received training in information governance. Systems were in place to manage test results and letters, including hospital discharge summaries, out-of-hours services and the 111 telephone advice service. Daily reports were produced to identify patients discharged from hospital and ensure any follow up actions were completed, for example; medication changes, reassessment or additional carer support.

The practice took a holistic approach to patient care. There was close working with health visitors, midwives and school nurses. Local multidisciplinary team meetings reviewed children at high risk. Monthly multidisciplinary meeting were held with staff from other GP practices in the local network, secondary care, community nursing, social care and voluntary sector organisations to review patients with complex needs. The minutes of these meetings included the aims of multi-agency working and lessons learnt. The practice also worked with other local practices and Barnados to improve ways of engaging with young people

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice participated in the local diabetes care programme (Bradford Beating Diabetes) to support the identification of patients at risk of developing diabetes and ensure they receive the appropriate advice, care and support to prevent or delay the onset of the condition. The practice had been commissioned to provide an enhance diabetes (level 2) service and accepted patients referred from other practices for insulin initiation and monitoring.

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 securely. Electronic systems were also in place for making 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). A named member of staff was responsible for liaising with patients and assisting them to navigate the referral and booking system.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. Staff were fully trained on the system, which enabled scanned paper communications, such as those from hospital, to be saved within the relevant patient's case notes for future reference.

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

There was a practice consent protocol for staff to follow. Staff were aware of their responsibilities to comply with the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Clinical staff understood the key parts of the legislation and were able to describe how they implemented it in their practice, including situations where 'best interests' decisions were necessary for children or adults who lacked capacity. For example, patients with complex needs such as a learning disability or dementia, were supported to make decisions through the use of care plans. These care plans were reviewed quarterly. Clinical staff also demonstrated clear understanding of Gillick competencies. These were used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions.

Health promotion and prevention

The practice was proactive in promoting improvement in health. A health champion had been recruited and worked in the practice one day a week to promote health improvement and organise community health promotion events. There were regular meetings with the local Clinical Commissioning Group (CCG) to share information and discuss the needs of the practice population. The practice supported local initiatives, such as the Bradford Beating Diabetes programme, to improve the health of the local population. The clinical staff offered advice on health promotion, including smoking cessation, weigh management, diet and exercise. Chronic disease management clinics were available and the practice also provided spirometry, phlebotomy and ECG services for patients.

There were systems to identify patients who needed additional support, including social care needs. For example, during registration and whilst carrying out new patient health checks. Health promotion information was available on the practice web site and in the practice waiting area. New patient information packs included health promotion leaflets and details of other organisations and services. Information was provided about self-help groups and patients were encouraged to self-refer.

The practice maintained a register of housebound patients. Home visits to complete chronic disease management reviews and vaccinations were carried out by an advanced nurse practitioner. Health checks were offered to all new patients registering with the practice and all patients aged between 40 to 75 years. One member of staff had been given a liaison role, working with other local organisations and services to ensure patients received appropriate community support. Benefits advice was also available within the practice.

The practice's current (2014/15) performance for cervical smear uptake was 78%. National data for 2013/14 indicated that the practice had achieved 85% which was better than the England average of 82%. Childhood immunisations, travel vaccines and flu vaccinations were offered in line with current national guidance. The practice performance for childhood immunisations in the year 2013/14 was 99%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available from the national GP patient survey (January 2015) on patient satisfaction. Out of the 449 surveys sent out to patients a total of 54 (12%) had been returned. The results showed that 85% of patients who responded said they usually got to see or speak to their preferred GP (CCG average 42%) and 77% said they would recommend the surgery to someone new to the area (CCG average 59%). In response to other questions the practice was rated at similar levels to the average for the CCG area. For example; 91% had confidence and trust in the last GP they saw, 86% said the last appointment they had was convenient and 71% were satisfied with the practice opening times.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 38 completed cards. The majority were very complementary about the staff and the service they experienced. Patients said they felt the practice offered an excellent service and staff were helpful and caring. They said they were treated with dignity and respect. Two comments were less positive but there were no common themes to these. One was in relation to a delay in obtaining an appointment and the other about not being put at ease when speaking to their GP. We also spoke with three patients on the day of our inspection. They all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Curtains were provided in consulting rooms and treatment rooms so that patient's privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The reception area was small and because of the physical limitations of the building patient seating was relatively close to the reception desk. The practice was aware that privacy and confidentiality were difficult to maintain when staff spoke with patients at the reception desk. The practice had introduced measures to improve privacy, such as requesting that only one patient at a time approach the reception desk and providing a private interview room for patients to use. However it was also acknowledged that provision of a larger waiting area more appropriate for the practice patient list size was required.

Care planning and involvement in decisions about care and treatment

Patients whose first language was not English were able to access support from a translation service. Staff were often able to support patients in their own language. Between them the staff at the practice spoke a total of 11 different languages. The practice web site included a tool which enabled patient to view information in any of 90 different languages. A hearing loop was available to assist patients with hearing impairments. Improvements had been made to practice signage to help patients identify consulting or treatment rooms.

The national GP 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 well in these areas. For example, data showed that 93% of the patients who competed the survey said the last nurse they saw or spoke to was good at involving them in decisions about their care (CCG average 77%). In relation to other questions; 80% said the last GP they saw or spoke to was good at explaining tests and treatments (CCG average 74%) and 73% said the last GP they saw or spoke to was good at involving them in decisions about their care (CCG average 65%).

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Patient/carer support to cope emotionally with care and treatment

We were told that all the staff were encouraged to respect privacy, maintain patient's dignity and show compassion. All the administrative staff had undertaken customer care training. Responses provided on patient comment cards

Good

Are services caring?

also indicated that staff acted in ways which were caring and compassionate. For example, noting that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. Information about coping with bereavement and depression were available. The practice also offered patients advice and support about social care needs assessments and requests for equipment or adaptations to their home to enable them to maintain their independence

The practice's computer system alerted staff if a patient was also a carer. The practice worked with a local carers' resource organisation and invited representatives to attend the regular multidisciplinary care meetings. Staff told us that if families had suffered a bereavement, their usual GP visited them and offered support and advice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to 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. We were told that 31 different languages were spoken by patients registered with the practice and in response staff had been recruited from a range of backgrounds and language skills. There was a good awareness of the differing cultural needs of the patient population. The practice manager was a member of the local Central Eastern European Liaison Service (CEELS) and had worked with them to produce a multilingual guide to health services.

Specialist clinics were provided for the management of conditions such as diabetes and asthma or baby health checks and childhood immunisations. Antenatal clinics were provided by the midwifery team.

The practice had introduced the Bradford Pharmacy First scheme and also offered social prescribing. Pharmacy First is a service to provide local people with rapid access to a pharmacist who can give advice and support and, where necessary, can also dispense medicines without the need for a doctor's appointment. Social prescribing gives patients with non-clinical needs access to local voluntary services and community groups, such as coffee mornings, weekly walking groups and , self-care events, aimed at helping to improve social engagement and well-being. The practice told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Self-referral access was available to psychological therapies. The practice worked with a local south Asian community health service (IHSAN) to provide counselling, employment and social support.

Tackling inequity and promoting equality

The practice worked with the Clinical Commissioning Group (CCG), other GP practices, Healthwatch and local organisations to meet the needs of the population. For example, contributing to the Bradford Beating Diabetes project and the Bradford Integrated Care for Adults programme. These multiagency meetings were also used to raise awareness of services in the area which may be beneficial for other patients.

The practice staff spoke 11 different languages. They had received e-learning training in equality and diversity issues. They had access to online and telephone translation services. We were told that interpreters were also utilised to telephone patients at home and remind them about attending recall or follow-up appointments.

Access to the service

The practice was situated on the first floor of the a community health centre. There was stair and lift access. The waiting area was relatively small for the number of patients visiting the practice. however, the practice had made good use of the space available and had raised the issue of additional space with the building managers.

The practice was open from 7.00am until 6.00pm on Mondays, Thursdays and Fridays and from 8.00am to 6.00pm on Tuesdays and Wednesdays. Between 1 November 2014 and 31 March 2015, as part of the NHS winter pressures initiative, the practice opened from 9.00am to 11.30am on Saturday mornings. Each weekday morning patents were able access a 'Same day service' from 9am-9.30 am. This service, which was triaged by the duty doctor, offered advice, prescriptions, a routine GP appointment or an emergency same day appointment with the doctor or the nurse practitioner. Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments on-line. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed.

Comments received from patients showed that they were satisfied with the appointments system and could usually get a convenient appointment. Results from the most recent (January 2015) national GP patient survey showed that 86% of the practice patients who responded said the last appointment they had was convenient and 71% were satisfied with the practice opening times.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated responsible person who handled all complaints in the practice. Information

Good

Are services responsive to people's needs?

(for example, to feedback?)

about the complaints procedure and contact details for local support and advocacy organisations was available in the waiting area and in the practice leaflet. The patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at summaries of the six complaints received in the last 12 months and at three in detail. Each complaint had been investigated and a response letter sent to the patient. Complaints were analysed and an annual report prepared to identify possible trends. Individual complaints or concerns were discussed at practice meetings to consider potential learning points. The practice did not formally record verbal complaints, however, we were told these were raised at staff meetings. The practice may wish to consider implementing a recording system, similar to that used for written complaints, to assist in the identification of any patterns or trends.

The practice sought patient's views about the service. Information and meeting records about the patient engagement group was available on the practice website. The practice also worked with Healthwatch which held patient feedback sessions at the community health centre and provided a report to the practice on comments made by patients. We saw a copy of a report from September 2014 which included comments from five patients. These were consistent with comments made during our visit and those made in response to the national GP patient survey.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice described its mission as being;

To deliver high quality care and improve the health, well-being and lives of its patients. To improve the health, well-being and lives of those we care for, to provide the highest quality healthcare under the NHS to all our patients by a well-trained and motivated primary health care team.

A copy of the mission statement, together with the practice's Statement of Purpose, were available on the practice website. There was a strong emphasis on promoting awareness of the practice mission. The mission statement was displayed in the practice together with statements which emphasised the importance of patients and their needs.

Governance arrangements

The practice had a comprehensive range of policies and procedures in place to govern activity. Copies of all the policies and procedures were available to staff on the practice IT system. There was a clear leadership structure with named members of staff in lead roles. There were regular practice meetings to monitor the effectiveness of systems and procedures and improve the service.

The GP partners took lead roles for clinical and non-clinical areas of the practice, for example prescribing, integrated care or information governance. One of the advanced nurse practitioners was the lead for women's health and a healthcare assistant lead on infection control. Staff were clear about their own roles and responsibilities. They felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure performance. QOF data was continuously monitored and regularly discussed at practice meetings to maintain or improve outcomes for patients. The QOF data for this practice showed it was performing highly compared to other practices.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a range of potential issues, such as repeat prescribing. The risk log was regularly discussed at team meetings and improvement actions implemented.

Leadership, openness and transparency

The practice manager was responsible for human resource policies and procedures. These included policies for; the appointment and induction of staff and staff appraisal, training and development. Staff told us that there was an open culture within the practice and they were encouraged to raise issues and make suggestions to improve the service. They said they felt well supported and there was a good team spirit which focussed on a holistic approach to patient care.

Seeking and acting on feedback from patients, public and staff

The practice sought feedback from patients through; patient surveys, suggestions, engagement events and complaints. The practice considered how any changes to the running of the practice might affect patients. For example, before making changes to telephone access at lunchtimes the practice consulted patients to assess the potential impact.

The practice had sought to develop a Patient Participation Group (PPG) but found interest was low and members had ceased to meet. As an alternative a part-time patient engagement officer had been recruited to develop the role of practice health champions, volunteers who after training helped to deliver health and wellbeing activities to patients and the wider community. Details about the health champions, meeting minutes and activities were available on the practice website. Activities they had supported included, a health information day, walking groups, social meetings such as coffee mornings and self-care.

Management lead through learning and improvement

The practice was part of the Productive General Practice Scheme. This scheme supports practices to review their systems and procedures, develop business planning and focus on strategic priorities to improve efficiency and the service available to patients. Staff were supported to maintain their clinical and professional development

Are services well-led?

Good

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

through training and supervision. An external training agency had been appointed to deliver training programmes which were appropriate for differing staff roles.

Information and learning gained through staff development events, clinical audit, complaints, reviews of significant events and other incidents were shared with staff at meetings to improve outcomes for patients.

For example, the practice supported university medical students gain experience of primary care. Student feedback about the knowledge and skills they gained whilst on placements at the practice was used to improve the service. Whole practice training events, for example improvements in infection control, were also used to assist staff in maintaining their awareness of and knowledge of how to ensure essential standards were met.