The Northolme Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Northolme Practice on 17 March 2015. Overall the practice is rated as good.

Specifically we rated the practice as good in providing safe, effective, caring, responsive and well-led care for all of the population groups it serves.

Our key findings were as follows:

- Patients said they found it easy to make an appointment with a preferred GP, there was continuity of care and urgent appointments were available the same day.
- 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 were involved in care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Complaints were addressed in a timely manner and the practice endeavoured to resolve complaints to a satisfactory conclusion.
- 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.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

However, there were also areas of practice where the provider needs to make improvements.

The provider should:

- Ensure that records are available to show what training staff had and when, to enable the practice to monitor the training needs of staff in general

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, to report incidents and near misses. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. Some staff had not received fire safety training since 2012. However, they told us what they would do in the event of a fire and knew how to use relevant equipment.

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 the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed, care planned and delivered in line with current legislation. This included assessing capacity and promoting good health. There was evidence of annual appraisals and staff had received training appropriate to their roles. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others for several aspects of their care. Patients said they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment. Care planning templates were available for staff to use during consultation. Information to help patients understand the services was available and easy to understand. We saw staff treated patients with kindness, 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. Patients said they found it easy to make an appointment with a preferred GP, there was continuity of care and urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. 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. There was a clear leadership structure and staff felt supported 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. Staff received induction, regular performance reviews and attended staff meetings. The practice proactively sought feedback from patients and staff which it acted upon. The Patient Participation Group (PPG) was active and the practice engaged and listened to suggestions made by the group. For example, disabled parking spaces had been designated and electronic doors installed to the practice entrance.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. All patients over 75 years of age had a named GP. There were systems in place for older people to receive regular health checks. There were a range of enhanced services available. For example, every person over 75 was offered a dementia screening test. The practice was responsive to the needs of older people, offering home visits and longer appointments. The practice working closely with other health and social care professionals. All residential and nursing home patients registered with the practice had a named GP.

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 such as diabetes and chronic obstructive pulmonary disease (COPD). There were structured annual reviews in place to check the health and medications needs of patients were being met. Longer appointments and home visits were available when needed. Staff worked with relevant health and social 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 living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. The practice provided sexual health support and contraception, maternity services and childhood immunisations. Data showed immunisation rates were above average for Calderdale Clinical Commissioning Group (CCG). Appointments were available outside of school hours and the premises were suitable for children and babies. The practice told us that all young children were seen on the same day as requested.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice had extended hours, including pre-bookable early morning appointments. The practice also had a branch surgery which enabled patients to access appointments at either location. The

Summary of findings

practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of this age group. For example, all patients over the age of 40 were offered a cardio-vascular disease (CVD) check.

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 advised vulnerable people how to access various support groups and voluntary organisations. It regularly worked with multidisciplinary teams in the case management of vulnerable people. For example, all patients with a known drug addiction were referred, with their consent, to the local substance misuse service. The practice held a monthly shared care clinic for those patients who were on maintenance treatment.

Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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 for all patients who had poor mental health or dementia. There was a GP lead for mental health. The GPs actively screened patients for dementia and maintained a list of those diagnosed. The practice regularly worked with multidisciplinary teams in the case management of people in this population group. The practice informed patients how to access various support groups and voluntary organisations. For example, Insight (a local talking therapy service) and Improving Access to Psychological Therapies (IAPT).

Summary of findings

What people who use the service say

We received seven CQC comment cards and spoke with five patients and a member of the patient participation group (PPG) on the day of our visit. All the comments on the cards were positive and complimentary about the practice and the staff. Patients we spoke to told us the clinicians listened to them, explained treatments and involved them in decisions about their care. They told us they were treated with dignity and respect and staff were polite.

The majority of patients were complimentary about the appointment system and they often received a same day appointment. They told us they sometimes had to wait longer if they wanted to see a doctor of their choice.

A member of the PPG told us the practice was proactive in supporting the group and had acted on issues raised by the group. For example, provided disabled car parking spaces and also had electronic access doors to the practice installed.

We looked at the National Patient Survey (January 2015), which had sent out 256 surveys and received 118 responses (46% completion rate). One hundred per cent of respondents rated their overall experience of the practice as 'very or fairly good', compared to the CCG average of 86%.

The results showed the practice to be above average for the CCG in many areas. For example, 80% of respondents usually got to see/speak to a preferred GP (CCG 61%) and 87% waited 15 minutes or less after their appointment time to be seen (CCG 70%). Ninety five per cent 95% of respondents would recommend this surgery to someone new to the area, compared to the CCG average of 79%.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that records are available to show what training staff had and when, to enable the practice to monitor the training needs of staff in general

The Northolme Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Northolme Practice

The Northolme Practice provides General Medical Services (GMS) for a population of 14207 patients under a contract with NHS Calderdale Clinical Commissioning Group (CCG). The practice is registered to provide the following regulated activities: treatment of disease, disorder or injury; family planning; maternity and midwifery services; diagnostic and screening procedures. The Northolme Practice is a training practice accommodating both registrars and medical students.

The practice has a main branch, Kos Clinic, based within the Hipperholme area of Halifax. It is situated within a purpose built building which opened in 1984 and was extended in 2002, with the addition of The Annexe. The extension is joined to the main building by a covered walkway and has its own reception area.

The practice also provides services at a branch surgery approximately two miles away at the Northowram Surgery. We did not visit the branch surgery as part of this inspection.

There are six GP partners (four male and two female) at the practice. They are supported by two nurse practitioners, three practice nurses and a health care assistant. The clinical staff work across both sites. An experienced team of management, administrative and reception staff support the practice at both sites.

The practice opening times are Monday to Friday 7.30am to 6pm. Patients can access the appointment system at reception, by telephone or online via the practice website. Some appointments are pre-bookable and others are bookable on the day. A duty doctor is available each day to see or advise patients who need to be dealt with as emergencies. Out of hours care is provided by Local Care Direct.

Why we carried out this inspection

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

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

How we carried out this inspection

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

Detailed findings

We carried out an announced inspection visit at the main branch, Kos Clinic, on the 17 March 2015. During our visit we spoke with a range of staff, including two GPs, the practice manager, the office manager, the IT manager, the clinical information manager, a practice nurse, a health care assistant, a medical secretary and a receptionist. We also spoke with five patients who used the service and a member of the PPG.

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

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

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

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

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

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 showed the practice had managed these consistently and could demonstrate a safe track record over the long term.

Learning and improvement from safety incidents

There were systems in place for how the practice managed safety alerts, significant events, incidents and accidents. Significant event analysis was a standing agenda item on the weekly clinical meetings. They were also discussed at the monthly practice meeting. Some administration staff told us they could not always attend the monthly meetings but were aware of what incidents had taken place and the actions taken. Staff we spoke with confirmed there was an open and transparent culture. They knew how to raise issues for discussion and were encouraged to do so.

The practice manager showed us the system they used to manage and monitor incidents and the procedure for reporting these. We looked at twelve records of reported incidents and saw they had been completed in a comprehensive and timely manner. They included learning points or improvement actions. We looked at one significant event in detail regarding a prescribing error. A patient had requested a prescription over the telephone for a medicine which had been prescribed by a consultant. The name of the medicine had been misheard and resulted in a prescribing error. As a result it was agreed by the practice requests for prescriptions would not be taken over the telephone.

Reliable safety systems and processes including safeguarding

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

The practice had a designated GP lead in safeguarding vulnerable adults and children, who had completed level 3 safeguarding training. All staff we spoke with were aware of who the lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system in place to highlight vulnerable patients on the practice's electronic record. The practice held a monthly meeting with other health professionals, such as the health visitor, to discuss concerns and share information about children and vulnerable patients registered at the practice.

There was a chaperone policy in place which was available in the reception area. Reception staff acted in the capacity of chaperone when required and could explain what their roles and responsibilities were. We saw evidence staff had received chaperone training in 2012. (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 who undertook chaperone duties had been checked through the disclosure and barring service (DBS).

Medicines management

We checked medicines stored in the treatment rooms and found they were stored securely and only accessible to authorised staff. We checked the refrigerators where vaccines were stored. Staff told us the procedure was to check the temperatures on a daily basis and record it. We saw evidence of daily records being kept 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. We looked at a selection of vaccines and found they were within their expiry date. Expired and unwanted medicines were disposed of in line with waste regulations.

There was a repeat prescribing protocol in place. Requests for repeat prescriptions were taken in person at the reception desk, by post or over the internet and we were informed about checks that were made to ensure the

correct patient was given the correct prescription. All prescriptions were reviewed and signed by a GP before they were issued to the patient. There were procedures in place for GP six monthly reviews and monitoring of patients who took medication for a long term condition.

The data from Calderdale CCG which related to the practice's performance for antibiotic prescribing showed them to be comparable to similar practices.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice. All prescription forms were kept in a cupboard within a locked room which was only accessed by authorised staff.

Cleanliness and infection control

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

An infection prevention and control (IPC) policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves and aprons were available for staff to use. Hand washing sinks with hand soap, 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 and staff told us how they would respond to blood and body fluid spillages in accordance with current guidance.

The practice had a lead for IPC. Staff we spoke with were aware of the procedures in place to minimise the risk of cross infection and how to deal with a needle stick injury. However, it was not clear when staff had last received any IPC training. The practice manager told us they would source IPC training for all staff.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us a schedule was in place to ensure all equipment was tested and maintained regularly. All portable electrical equipment was routinely tested. The sample of equipment we inspected had up to date Portable Appliance Tests (PAT) stickers displaying the last testing date. We saw evidence of calibration of equipment where required, for example weighing scales and blood pressure measuring devices.

Staffing and recruitment

Records we looked at contained evidence of appropriate recruitment checks having been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal record checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy in place.

Staff told us about the arrangements for planning and monitoring the number and mix of staff required by the practice to meet the needs of patients. There was an arrangement in place for members of staff, this included clinical and non-clinical, to cover each other's annual leave and sickness. They told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

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

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

Health and safety information was displayed for staff to see and a health and safety policy was in place.

Arrangements to deal with emergencies and major incidents

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

Emergency medicines were available in a secure area of the practice. They included medicines for the treatment of

Good

Are services safe?

cardiac arrest, anaphylaxis and hypoglycaemia. Staff told us equipment and emergency medicines were checked on a daily basis. Although we saw some records of checks had been undertaken, it was unclear whether this was done daily and whose responsibility it was. The practice has since advised us they now have an appropriate system in place. We checked the equipment and medicines at the time of inspection and found all medicines were in date and the equipment was fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice.

Some staff had not received fire safety training since 2012 but told us they were aware of what to do in the event of a fire and knew how to use relevant equipment. The practice manager has since told us fire safety training has now been organised for all staff to attend.

Good

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 clinicians held weekly practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed.

We were informed GPs had a lead in specialist clinical areas such as diabetes, heart disease and palliative care. The practice screened patients for cardio-vascular disease (CVD), diabetes and respiratory disorders such as chronic obstructive pulmonary disease (COPD) and asthma. The practice told us they undertook targeted screening for atrial fibrillation (atrial fibrillation is a hard condition which causes an irregular and often abnormally fast hear rate). All patients who attended for an influenza vaccination had a pulse check. If the pulse was found to be irregular the patient subsequently was referred for an electrocardiogram (ECG); a test that records the rhythm and electrical activity of the heart. The ECG was undertaken by the practice nurse who had been specifically trained. Any patients identified with an irregular ECG were then referred appropriately for further investigations. The practice told us between September 2014 and January 2015, 20 patients had been identified and referred.

The practice had registers for patients with long term conditions and palliative care. Patients had their condition 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. For example, retinopathy screening for people who have diabetes (retinopathy is commonly caused by diabetes and can affect vision). The practice nurse held a specific clinic for diabetes, where a podiatrist and dietician were also in attendance. This enabled patients to be assessed holistically during their diabetic review.

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.

Interviews with staff showed the culture of the practice was patients were cared for and treated based on need. The practice took into account a patient's age, gender race and culture as appropriate and avoided any discriminatory practises.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in how they monitored and improved 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.

Information collected for the quality and outcomes framework (QOF) and performance against national screening programmes 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.) In 2013/14 the practice was above both the local CCG and England average achievements for many of the QOF domains; particularly in depression, epilepsy, learning disabilities and osteoporosis.

Clinical audit, clinical supervision and staff meetings were used to assess performance. The practice had an effective system in place for how they completed clinical audit cycles. We were provided with summaries of six clinical audits which had been completed in the last twelve months. After each audit, actions had been identified and changes to treatment or care had been made. Where appropriate a repeat audit had been scheduled to ensure outcomes for patients had improved. For example, using new guidelines on the prescribing of antibiotics the GP had identified 15% of relevant patients who had been prescribed antibiotics for a longer period than was recommended. The GP made the clinical team aware of the audit results to ensure everyone followed the correct

Good

Are services effective?

(for example, treatment is effective)

guidelines and improved prescribing. The audit was repeated eleven months later and it had identified correct prescribing using the guidance had been maintained in 100% of appropriate patients.

We were told all patients who were on disease modifying antirheumatic drugs (DMARDs), such as methotrexate for rheumatoid arthritis, had their repeat prescriptions issued and printed by a GP rather than a receptionist. This practice policy had been in response to a previous audit which showed a significant number of patients had been issued prescriptions without having had the recommended three monthly blood monitoring test.

The practice had a palliative care register and held regular multidisciplinary team meetings to discuss the care and support of patients. The practice had achieved 100% QOF points in this area, which was 3.8% above the CCG average.

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 annual basic life support and safeguarding adults and children. However, we could not find evidence staff were up to date with fire safety and infection prevention and control training. The practice manager informed us they would source the training and ensure staff attended.

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

Practice nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. For example, cervical cytology and diabetes management. 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 they had received training necessary for their role.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff told us they felt supported in their role and confident they could raise any issues with the practice manager or the GPs.

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 multidisciplinary team (MDT) meetings to discuss the needs of palliative care patients. These meetings were attended by Macmillan nurses, members of the district nursing team and the community matron. 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 held a monthly shared care clinic with substance misuse services for patients who had a known drug addiction and had commenced maintenance treatment.

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 (OOH) provider to enable patient data to be shared in a secure and timely manner. A GP showed us how information regarding patients who were on end of life care pathways and/or had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place, was printed off from the patient's electronic record and faxed securely to the OOH provider.

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 which, in consultation with the patients, could be done through

Good

Are services effective?

(for example, treatment is effective)

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, the practice leaflet and website.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 and Children Acts 1989 and 2004, although we could not find evidence staff had received training in this area. The clinical staff we spoke with understood the key parts of the legislation and how they implemented it in practice. Staff told us what they would do in a situation if someone was unable to give consent, this included escalating it for further advice where necessary.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans. 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

The practice offered NHS Health Checks to all its patients aged 40 to 70 years and all patients over the age of 40 were offered a cardio-vascular disease (CVD) check. They were involved with national breast, bowel and cervical cytology screening programmes. Follow up of non-attenders was undertaken by the practice. The practice's performance for cervical smear uptake for 2013/14 was 86.2%, which was similar to other practices in the area.

They offered a full range of immunisations for children, flu vaccinations and travel vaccinations in line with current national guidance. Data showed childhood immunisation rates for the practice were above average for Calderdale Clinical Commissioning Group (CCG).

The practice had numerous ways they could identify patients who needed additional support. For example, they kept a register of all patients with a learning disability, long term condition or mental health problem. These patients were offered an annual physical health and well-being check. Systems were in place to refer or signpost patients to other sources of support, for example smoking cessation or weight management clinics.

There was evidence of health promotion literature available in the reception area and practice leaflet. The practice website provided health promotion and prevention advice and had links to various other health websites, for example NHS Choices.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information form the National Patient Survey (January 2015), where from a survey of 256 questionnaires, 118 (46%) responses were received. The survey showed 100% of respondents rated their overall experience of the practice as good and 96% said the GP treated them with care and concern and were good at listening to them. These were all above average for the CCG (86% and 91% respectively).

Patients completed CQC comment cards to tell us what they thought about the practice. We received seven 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.

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. The practice manager told us they would investigate these and any learning identified would be shared with staff.

We observed reception staff were courteous, spoke respectfully to patients and were careful to follow the practice's confidentiality policy. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. We observed conversations between patients and staff in the reception were not easily overheard.

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 90% of respondents said the GP involved them in care decisions and 95% felt the nurse was good at how they explained treatment and results. Both these results were above average compared to the local CCG.

The patients we spoke with on the day of our inspection 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 receive.

Clinical staff told us written care plans were undertaken in conjunction with patients who had a long term condition, these included self-management plans. For example, patients who had asthma were given information of when to 'step up or step down' medication dependent on their symptoms.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with on the day of our inspection and the CQC comment cards we received highlighted staff were caring and provided support when needed. Notices in the patient waiting area and on the practice website provided information on how to access a number of support groups and organisations. For example, written information was available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice told us they engaged regularly with Calderdale Clinical Commissioning Group (CCG) and other agencies to discuss the needs of patients and service improvements. 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. For example, longer GP and nurse appointments were available for patients who had complex needs or where they were supported by a carer. Patients with more than one long term condition had a single health check to avoid the need for multiple appointments. Home visits were also available for patients who found it difficult to access the surgery.

The practice provided a service for all age and population groups. Registers were maintained of patients who had a learning disability, a long term condition or required palliative care. These patients were discussed at the weekly clinical and monthly multidisciplinary meetings to ensure practitioners responded appropriately to the care needs of those patients.

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. For example, the practice now publicised the numbers of appointments where patients did not attend (DNA).

Tackling inequity and promoting equality

The practice had recognised the needs of the different population groups in the planning of its services. The practice had systems in place which alerted staff to patients with specific needs or who may be at risk. For example, patients who had a visual or hearing impairment were flagged on the computer system.

There was good disabled access to the building and all patient areas and consulting rooms were on the ground floor. The patient areas were sufficiently spacious for wheelchair and pram access. Accessible toilet facilities were available for all patients and included baby changing facilities.

Staff told us there was little diversity of ethnicity within their patient population. However, they told us how translation services could be accessed using language line (a telephone based system for patients who did not have English as a first language). Fact sheets were available in other languages on the practice website. The website also had a translate page function so patients could view the whole website in a language of their choice.

Access to the service

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey. This indicated patients were generally satisfied with the appointments system at the practice. For example, 84% of respondents described their experience of making an appointment as good (CCG 72%) and 83% of respondents found it easy to get through to the practice by telephone, which was higher than the CCG average of 73%. The majority of patients we spoke with said they found it easy to get an appointment but may have to wait longer to see a GP of their choice. At the time of our inspection the next available pre-bookable appointment was within 48 hours.

Information regarding the practice opening times and how to make appointments was available in the reception area, the practice leaflet and on the website. Patients could book appointments by telephone, online or in person at the reception. Some appointments were pre-bookable and some were allocated to be booked on the same day. Home visits were offered for patients who found it difficult to access the surgery.

The practice told us all children under five years of age were seen on the same day as requested.

A duty doctor was on call each day to see or advise patients who needed to be dealt with as emergencies. Extended hours appointments were available from 7.30am to 6pm each week day. We were told the GPs covered each other's annual leave to avoid a reduction in any appointments.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

A text messaging service was used to remind patients (who had consented to receive them) 24 hours prior to their appointment.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw information was available to help patients understand the complaints system both in the reception area and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. One of the patients told us they had previously made a complaint (not in the last twelve months) and the process the practice had followed. This reflected the practice complaints procedure.

We looked at how complaints received by the practice in the last twelve months had been managed. The records showed complaints had been dealt with in line with the practice policy and in a timely way. Patients had received a response which detailed the outcomes of the investigations. We saw actions and learning from complaints were shared with staff. For example, a patient had complained they had received a letter which had contained inaccurate information and it had been signed by a secretary rather than a GP. After review, it was agreed by the practice to change their procedure to ensure all letters which contained 'important information' should be signed by the GP.

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 had a clear vision to deliver high quality care and promote good outcomes for patients. The vision and practice values were documented in the practice statement of purpose. Not all staff we spoke with were clear about what the practice vision was. However, they described the practice values as being safe, caring and compassionate and told us patient care was a priority. These values were consistent with patients' experiences of the service.

Staff spoke positively about the practice, told us there was good teamwork and they felt valued as employees.

Governance arrangements

The practice had appropriate policies and procedures in place to govern activity and these were available to staff on the practice computer system. We looked at three of these policies and procedures and saw they had been reviewed annually and were up to date.

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.

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

The practice had arrangements to identify, record and manage risk. The practice manager showed us the risk log which addressed a wide range of potential issues. We saw the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, in relation to the management of medicines.

Leadership, openness and transparency

The practice held weekly clinical meetings and monthly team meetings. We saw from minutes performance, quality and risks had been discussed.

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. Systems were in place to encourage staff to raise concerns and a 'no blame' culture was evident at the practice.

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 12 members, the majority of whom were in the 55 to 75 age range. The group met three times a year and was supported by the practice manager and a GP. One of the members of the PPG attended Calderdale CCG health forum and provided feedback to the group. The PPG were encouraged to raise items for discussion and had made various suggestions which the practice had acted upon. For example, the group had identified the telephone system was causing problems for patients trying to get through to the practice. The practice consequently installed a new telephone system with additional lines and introduced a queuing system. The minutes of the most recent meeting (February 2015) were available on the practice website.

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. Staff also told us 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. They 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?

Good

(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.