

Moor Park Medical Practice

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Moor Park Medical Practice on 11 November 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for all of the population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- 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 the following area of outstanding practice:

- We spoke with the advanced nurse practitioner who told us they had 30 minutes dedicated at the beginning of each day to support learning.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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?

The practice is rated as good for safe. There were standard operating procedures and local procedures in place to ensure any risks to patient's health and wellbeing were minimised and managed appropriately. The practice learned from incidents and took action to prevent recurrence. Medicines were stored and managed safely. The practice buildings were clean and well maintained and systems were in place to oversee the safety of the building.

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. 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.

Good



Are services caring?

The practice is rated as good for caring. The patients who responded to Care Quality Commission (CQC) comment cards and those we spoke with during our inspection, gave positive feedback about the practice. Patients described to us how they were included in all care and treatment decisions and they were complimentary about the care and support they received.

Good



Are services responsive to people's needs?

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 Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice was responsive when meeting patients' health needs. There were procedures in place which helped staff respond to and learn lessons when things did not go as well as expected. There was a complaints policy available in the practice and staff knew the procedure to follow should someone want to complain.

Good



Are services well-led?

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

Good



Summary of findings

responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the management team. The practice had a number of policies and procedures to govern activity and held regular meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings.

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

The practice is rated as good for the care of older people. The practice made provision to help ensure care for older patients was safe, caring, responsive and effective. All patients over 75 years had a named GP. There were systems in place for older patients to receive health checks and timely referrals were made to secondary (hospital) care.

People with long term conditions

The practice is rated as good for the care of people with long-term conditions. There were systems in place to ensure patients with Long Term Conditions (LTC) received regular reviews. The practice nurse worked with patients to put care plans in place and patients with LTC's were given a dedicated number to contact the practice if they needed advice. Health care professionals were skilled in specialist areas and their on-going education supported them to follow best practice guidelines.

Families, children and young people

The practice is rated as good for the care of families, children and young people. They helped to ensure care for these patients was safe, caring, responsive and effective. The practice provided family planning clinics and childhood immunisations. Appointments were available with practice nurses and GP outside of school hours. There was health education information relating to these areas in the practice to keep people informed.

Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice had identified the needs of the working age population, those recently retired and students to enable services to be adjusted appropriately. The practice offered a range of appointments from 8.00am – 6.30pm and appointments could be booked in advance or on the day.

People whose circumstances may make them vulnerable

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

Summary of findings

those with learning disabilities. These patients received an annual health check and longer appointments were available where required. Access to translation services and a hearing loop were available when needed.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. There was information readily available throughout the practice advising patients of various support groups and organisations.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Data showed that 96% of patients with a physical and/or mental health condition had been offered support or treatment within the preceding 15 months.

The practice had access to professional support such as the local mental health team and psychiatric support as appropriate. Information was readily available through the practice advising patients of various support groups and organisations.

Summary of findings

What people who use the service say

We received 14 completed CQC patient comments cards where patients and the public shared their views and experiences of the service. We also spoke with three patients on the day of our inspection and this included a member of the Patient Participation Group (PPG).

The patients who had completed the CQC comments cards and those spoken with were complimentary about the level of care and treatment they had received. However, one of the comments cards gave negative feedback regarding the environment.

The patients we spoke with told us they were always treated with dignity and respect. They felt all the staff at the practice took time to listen to them and involved them in decisions about their care. However, one person told us they did not always feel listened to.

Outstanding practice

The provider allocated 30 minutes as dedicated learning time at the beginning of each day for the advanced nurse practitioner.

Moor Park Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a second CQC inspector and a GP.

Background to Moor Park Medical Practice

The Practice is situated in a single storey, purpose built building situated in the centre of a residential area in the inner city area of Bradford. It was built in the late 1960's and provides a range of consulting and treatment rooms with supporting administrative areas.

The service is provided by two GPs, one male and one female. In addition there is an Advanced Nurse Practitioner, a Practice Nurse and two Health Care Assistants. The clinical team are supported by a team of reception and administration staff.

The practice has a General Medical Services (GMS) contract. A GMS contract is the contract between general practices and NHS England for delivering primary care services. The registered list of patients is approximately 2,900.

The practice opening times are Monday to Friday 8.00am – 6.30pm, with the exception of Thursday when the practice closes at 1.00pm. Appointments can be booked in person and over the telephone.

In addition to this, the practice participated in the winter services scheme, opening Saturday mornings between 1 November 2014 – 31 March 2015.

When the practice is closed, urgent healthcare advice that is not a 999 emergency is provided by telephoning the local Out of Hours NHS 111 service.

A wide range of services are available at the practice and these include: vaccinations and immunisations, cervical smears, and chronic disease management such as asthma, chronic obstructive pulmonary disease (COPD) and diabetes.

Why we carried out this inspection

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

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

How we carried out this inspection

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

Detailed findings

We carried out an announced inspection visit on 11 November 2014. During our inspection we spoke with staff including a GP, an Advanced Nurse Practitioner, a Practice Nurse, a Patient Engagement Lead, the Practice Manager and reception staff.

We spoke with three patients visiting the practice, and we observed how patients were being spoken with on the telephone and within the reception area. We also reviewed 14 CQC comment cards where patients had shared their views and experiences 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)

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, they reported incidents and national patient safety alerts, as well as 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 a sample safety records, incident reports and minutes of meetings where these were discussed over the last six months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events and complaints. There was evidence the practice had learnt from these and the findings were shared with relevant staff. For example, childhood vaccinations being administered in the wrong order. We saw that clear learning outcomes had been identified as a result of the incidents reported.

Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at meetings and they felt encouraged to do so.

Staff could complete an incident form manually or electronically and these were submitted to the lead GP or the practice manager.

We spoke with the practice manager who gave us an example of a significant event involving a fast track (urgent cancer referral) which had been sent to the hospital on a Friday evening. The practice did not receive confirmation that the fax had been sent as the secretaries had left for the evening.

As a result of the incident, a fast track referral book had been introduced which all staff members were to use and sign when confirmation that the fax had been sent successfully had been received.

We were able to review minutes of meetings and saw updates from the Medicines and Healthcare Products Regulatory Agency (MHRA) had been discussed and actions required by the practice outlined.

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 staff had received relevant role specific training on safeguarding. The GPs at the practice had received level 3 training. We asked members of the medical, nursing and administrative team about their most recent training. Staff knew how to recognise signs of abuse and how they should report this.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware of who the safeguarding lead was and how to escalate a safeguarding concern within the practice.

A chaperone policy was displayed in the reception area for patients to see. 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. All nursing staff and three receptionists had been trained to be a chaperone.

The practice also had a dedicated administrative lead for safeguarding. They liaised with the GP lead regarding children who did not attend appointments (DNA's) and ensured a follow up appointment was made.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with regulations.

Are services safe?

We saw emergency equipment was available in the surgery which included emergency medicines. The practice had arrangements for managing medicines to keep patients safe. Correct procedures were followed for the prescribing, recording, dispensing and disposal of medicines. Staff we spoke with were aware of the accessibility of emergency drugs, and the action they should take in an emergency situation.

We saw records of practice meetings where actions as a result of prescribing were identified. For example, the practice were responsible for blood monitoring for patients that were prescribed Disease-Modifying Antirheumatic Drugs (DMARDs) to ensure it was safe to continue use. The practice had created a register to ensure patients had the appropriate tests before prescriptions were issued for further medication. DMARDs are a group of medicines used to ease the symptoms of rheumatoid arthritis.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The patients we spoke with told us they received regular medication reviews at least once a year or more often if necessary.

We saw evidence of medication audits the practice had been involved in and these included vitamin B prescribing in alcoholism and use of antipsychotics in dementia.

Cleanliness and infection control

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

The practice had a lead for infection control who was responsible for ensuring all areas of the practice were kept to the appropriate levels of cleanliness. Staff working at the practice had received infection control training. We saw evidence the lead carried out audits on a monthly basis and saw audits were completed on a quarterly basis by the cleaning company. All of the audits we reviewed were above required standards.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan

and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

We saw equipment was available to meet the needs of the practice and this included; a defibrillator and oxygen, which were readily available for use in a medical emergency. Routine checks had been carried out to ensure they were in working order.

We saw, portable appliance testing had been completed annually and systems were in place for routine servicing and calibration of medical equipment where required. The sample of portable electrical equipment we inspected had been tested and was in date.

Staffing and recruitment

Records we looked at 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). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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

Are services safe?

Staff 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 to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

The practice had developed clear lines of accountability for all aspects of patient care and treatment.

Areas of individual risk were identified and steps taken to address the issues. Posters relating to safeguarding and violence and aggression were displayed throughout the practice, all staff had access to a panic button to alert other members of staff should they encounter a difficult situation.

There was evidence the practice learned from incidents and responded to identified risk. The practice looked at safety incidents and where concerns had been raised, they looked at how this could have been managed better or avoided.

We saw emergency equipment was available in the surgery which included emergency medicines. The location of this equipment was clearly signposted throughout the practice to ensure all staff were aware of its location.

Arrangements to deal with emergencies and major incidents

A business continuity plan was in place to deal with a range of emergencies 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 access to the building. For example; the practice had an identified partner practice who they could work with in the event of loss of access to the building, they had also negotiated space in a local health authority building. The document also contained relevant contact details for staff to refer to. For example, the public health emergency planning team.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed staff were up to date with fire training.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The practice held multiple clinics where appropriate, to meet the needs of the practice population. These included those patients with long-term conditions, such as diabetes and COPD. Other clinics included: childhood immunisations, travel immunisations and weight advice.

The practice had registers for patients needing palliative care, diabetes, asthma and COPD. This helped to ensure each patient's condition was monitored and that their care was regularly reviewed. Additionally regular palliative care meetings were held and they included other professionals involved in the individual patient's care.

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

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included heart failure pathway audit which was carried out to review the number of referrals to secondary care. The results of the audit evidenced that as a result of implementing the pathway the practice had reduced referrals to secondary care by 75%.

We saw the practice had a system in place for monitoring patients with long term conditions (LTC) and this included

asthma, hypertension, Chronic Obstructive Pulmonary Disease (COPD), diabetes and learning disabilities. Care plans had been developed and they had incorporated NICE and other expert guidance.

We found clinical staff had a good awareness of recognised national guidelines. For instance they used National Institute for Health and Care Excellence (NICE) quality standards and best practice in the management of conditions such as diabetes.

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF). This aimed to improve outcomes for a range of conditions such as diabetes. The practice used the information they collected to help monitor outcomes for patients and the quality of services they provided.

The QOF data showed the practice was performing better than average for maintaining a register of patients aged 18 and over with learning disabilities. This helped to ensure these patients received the best care possible.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with mandatory courses such as annual basic life support. The GP we spoke with told us they were up to date with their professional development requirements and had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses. For example, one member of the reception team had expressed an interest in read coding and had been supported by the practice to attend a training course.

We spoke with one practice nurse who was being mentored by the GP partner to complete nurse practitioner training. They told us they received regular support and supervision to enable them to do this role.

The practice ensured all staff could readily update both mandatory and non-mandatory training and this was

Are services effective?

(for example, treatment is effective)

provided through e-learning and face to face. We spoke with the advanced nurse practitioner who told us they had 30 minutes dedicated at the beginning of each day to support learning. The practice manager told us newly employed staff were supported through the induction process in the first few weeks of working in the practice.

Working with colleagues and other services

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

The practice used a computer system to store patient records. Staff input data such as discharge letters and blood results into the electronic records. The GP reviewed the information and acted where appropriate.

Information sharing

Staff had access to electronic systems relevant to their role and all staff had access to up to date practice policies and procedures. Staff told us they were kept informed by the practice manager if there had been any changes to policies and procedures.

Staff told us they had regular meetings and update meetings. These took place monthly and whenever there were things to be discussed. We were able to review minutes of these meetings and saw they covered a wide range of topics. For example; safeguarding, significant events and complaints.

We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. There were regular meetings with the multi-disciplinary team within the locality. These included palliative care nurses, community matron, and the safeguarding teams.

The electronic system enabled timely transfer of information with the out of hour's providers and this included the local hospitals and community staff. The GP reviewed all information received and actioned where appropriate.

The practice published a quarterly newsletter to share information about the practice and services with patients. We reviewed a copy and saw it contained self-help information and details of local initiatives the practice were involved with.

Consent to care and treatment

We found the healthcare professionals understood the purpose of the Mental Capacity Act (2005) and the Children Act (1989) and (2004). All staff we spoke with understood the principles of gaining consent including issues relating to capacity.

They also spoke with confidence about Gillick competency assessments of children and young people, which were used to check whether these patients had the maturity to make decisions about their treatment.

Patients felt they could make an informed decision. They confirmed their consent had been sought and obtained before any examinations and were aware of how to request a chaperone should they require one.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

All patients over 75 years had a named GP and received an annual health check. Patients with a long term condition or mental illness had an annual review of their treatment, or more often where appropriate. Dementia screening also took place.

A GP and nursing team led on the management of long term conditions (LTCs) of patients in the practice. They proactively gathered information on the types of LTC patients present with and had a clear understanding of the number and prevalence of conditions being managed by the practice.

The practice were involved in Bradford Beating Diabetes, a local initiative aiming to identify patients who are at risk of developing diabetes and ensuring they received the appropriate advice and support to prevent the condition.

Are services effective?

(for example, treatment is effective)

The practice were also involved in self-care week which involved displaying self-help information and encouraging patients to take control of their condition and take preventative steps rather than reactive.

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 from the National patient survey, and a survey of 100 patients undertaken by the practice. The evidence from these sources showed the majority of patients were satisfied with how they were treated by the practice, with only 1% of respondents stating they were unhappy with the practice as a whole. The information indicated that patients felt they were treated with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'average' for patients who indicated the GP and nurse was good or very good at treatment them with care and concern.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 14 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to these. 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.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms 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.

Care planning and involvement in decisions about care and treatment

The 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. The majority of patient feedback on the comment cards we received was also positive and aligned with these views.

There were translation services available for patients who did not have English as a first language. Reception staff at the practice were bilingual and provided interpretation services for those patients who required assistance.

Patient/carer support to cope emotionally with care and treatment

We saw information in the practice about advocacy, and bereavement support services. Staff were also aware of contact details for these services when needed. Information was also available on the practice website.

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

Palliative care meetings with clinical staff and community health professionals were held to discuss patient treatment, care and support. This ensured they received co-ordinated care and support.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice was accessible to patients with mobility difficulties. The consulting rooms were accessible for patients with mobility difficulties.

There was disabled parking available and the access and facilities within the practice, complied with current requirements.

Patients had access to translation services when needed. The translation service was provided by three members of staff at the practice who were bilingual.

The practice had also in response to the patient participation group (PPG), implemented suggestions for improvements to the way it delivered services. For example, patients had experienced difficulty when trying to get an appointment. In response to this, the practice actively focused on reducing the number of appointments wasted when patients did not attend (DNA). By introducing a text messaging service to remind patients about their appointments and educating them about the number of DNA's each month, the practice reduced the overall number of missed appointments by 50%.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services and therefore arranged for speakers from other organisations to educate patients.

We reviewed minutes of meetings and saw that speakers from Womenzone, a local community centre providing specialist women's and children's services aimed to make a difference to their lives and general well-being and Nirvana, a charity organisation offering help and support to people in forced or abusive marriages.

Child health, immunisations and vaccination clinics were held.

All patients over 75 years had a named GP. There were systems in place for older patients to receive regular health checks, and timely referrals were made to secondary (hospital) care. Information was available to carers and the practice kept a register of these patients.

Patients with a long term condition such as asthma and diabetes, had care plans in place. These were shared with the patient and helped offer the patient a better overall experience in meeting their needs. Healthcare professionals were skilled in specialist areas and their on-going education supported them to follow best practice guidelines.

Access to the service

Information was available to patients about appointments in the practice waiting room, on their website and in the practice leaflet. This included how to arrange urgent appointments and home visits and how to book and cancel appointments.

The practice offered a range of appointments between 8.00am and 6.30pm Monday to Friday, with the exception of Thursday when the practice closed at 1.00pm. Appointments were available to book on the day and book in advance.

In addition to this, the practice participated in the winter services scheme, opening Saturday mornings between 1 November 2014 – 31 March 2015.

Patients could access appointments by telephoning the practice and attending in person. The practice manager also told us they had arranged to have training to enable patients access to online booking.

When the practice was closed, urgent healthcare advice that was not a 999 emergency was provided by telephoning the Out of Hours NHS 111 service.

Results from the national patient survey, demonstrated patients were happy with most aspects of the service. For example, one of the questions asked in the survey was 'Generally, how easy is it to get through to someone at your GP surgery on the phone' An average number of patients stated they were very satisfied or fairly satisfied with their practices opening hours.

Are services responsive to people's needs?

(for example, to feedback?)

The GPs and staff told us emergency, same day appointments were always available. Home visits were also available where appropriate, and included visits to patients who were house-bound.

Nurse appointment could be booked routinely for a variety of conditions and health promotion, including: Asthma, COPD, Hypertension and Diabetes.

Repeat prescriptions were available to re-order either in person or on-line. Information relating to this was available in the practice leaflet and on their website.

Listening and learning from concerns and complaints

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

We saw information was available to help patients understand the complaints system. For example, there was information available in the waiting room and a box provided for comments and complaints. Information was also available in the practice leaflet and on their website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at one complaint received in the last 12 months and found this had been dealt with in line with the practice policy and learning points and outcomes had been documented.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Are services well-led?

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

Our findings

Vision and strategy

The practice had a clear vision to provide the best possible treatment and advice at all times and to help keep patients and their families healthy. We found details of the vision and practice values outlined in The Practice Charter. The Practice Charter was available to patients in the practice leaflet and on the website. The Practice Charter outlined the practices' commitment to patients and also outlined what the practice expected from patients. For example; 'treating patients as individuals, with courtesy and respect at all times and offering patients the most appropriate care, given by suitably qualified people who will explain your condition and treatment programme to you in a simple and understandable way.'

We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had management systems in place. They had policies and procedures to govern activity and these were accessible to staff. We saw the policies incorporated national guidance and legislation.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for infection control and safeguarding within the practice. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice 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.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk assessments which had been carried out in relation to fire, legionella and premises.

The practice held monthly clinical and administrative meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

The practice was committed to on-going education, learning and individual and team development of staff. The performance of staff was the subject of monitoring and appraisal at all levels; which reflected the organisational objectives.

There was good communication between staff. The practice had a proactive approach to incident reporting. They discussed if anything however minor could have been done differently at the practice.

We were able to review a range of policies including confidentiality, information governance and complaints. These clearly outlined responsibilities and timescales.

Staff we spoke with told us all members of the management team were approachable, supportive and appreciative of their work. They were encouraged to share new ideas about how to improve the services they provided. Staff also spoke positively about the practice and how they worked collaboratively with colleagues and health care professionals.

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

The practice had gathered feedback from patients through patient surveys, comments cards and an established patient participation group (PPG). Feedback from the PPG raised issues around difficulties getting an appointment and requests for information regarding community run groups for male patients.

We saw the practice had done further work as a result of this by following up patients who did not attend for appointments and publishing how many appointments had been wasted by DNA's. In addition the practice had introduced a text message reminder service to support patients to attend pre-booked appointments which had resulted in a reduction in DNA's of almost 50%.

We reviewed minutes of PPG meetings and saw evidence that a patient had been accompanied to an over 55's event by the patient engagement lead. This evidenced the practice were taking action in response to suggestion from the PPG.

Management lead through learning and improvement

Are services well-led?

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

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us annual appraisals took place, which included a personal development plan. We looked at two staff files and saw evidence of this.

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. The incidents reported by the practice included vaccination errors, a delayed fast track referrals and patient information errors. We saw evidence of this in minutes of meetings and logs of events/incidents.