The Whitfield 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

The Whitfield Practice is situated in the Hunslet area of Leeds. It provides a range of primary care services including access to General Practitioners (GPs), minor surgery, family planning, ante and post natal care to approximately 7700 patients from its surgery at the Hunslet Health Centre on Church Street Leeds. The practice has six GPs, two practice nurses, two health care assistants, a practice manager and other reception and administrative staff.

The practice is registered with the Care Quality Commission to the regulated activities:

- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Treatment of disease, disorder or injury.

We inspected this service on 15 October 2014 as part of our new comprehensive inspection programme. As a result of that inspection we rated the practice as Good.

We rated the practice as good for the quality of care it provided to the six population groups that we examined. These include older people, people with long term conditions, families with children and young people, working age people, people whose circumstances make them vulnerable and people experiencing poor mental health. The practice ethos is to strive towards a partnership between patients and health professionals based on mutual respect, holistic care and continuity of care. All staff in the practice demonstrated how the needs of different groups of patients were considered and appropriate care provided. The comment cards that were completed by patients prior to our visit and patients interviewed on the day were all complimentary of the quality of care they received and several commented on how they felt the GPs were very caring.

We rated the practice as good for how effective and caring its services are and for safety, responsiveness and how well led its services are. Our key findings were as follows:

- the practice provided effective services to its patients and treated them with dignity, care and respect
- treatment provided to patients was appropriate to their needs and reflected best practice guidelines.

Summary of findings

However there are areas of practice where the provider should improve by:

- ensuring regular checks are completed on emergency equipment.
- undertaking audits in order to ensure effective infection control practice within the practice.
- engaging patients about how the practice might improve.
- developing a strategic forward plan for the 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?

Good

The practice is rated as good for safe. Staff understood their responsibilities to raise concerns, and report incidents and near misses. When things went wrong, reviews and investigations were thorough and lessons learnt were communicated to support improvement.

Are services effective?

Good

The practice is rated as good for effective. NICE guidance is available and used routinely. People's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity. Staff have annual appraisals and receive training appropriate to their roles. Multidisciplinary working was evidenced. The practice undertakes clinical audits and uses the findings of these to improve patient care.

Are services caring?

Good

The practice is rated as good for caring. The practice should seek to improve the arrangements at reception so that patient confidentiality can be maintained. All the patients we spoke to during our inspection were very complimentary about the way they were treated by all staff within the practice. They were treated with empathy, care and respect and involved in decisions about their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The service was aware of the varying needs of the local population and had processes in place to address these, including having staff who could speak different languages. Patient feedback reported that access to a named GP and continuity of care was not always available quickly although urgent appointments were usually available the same day. Accessible information was provided to help patients understand the complaints system. Complaints were dealt with appropriately.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a vision for the way it wanted to provide services to its patients. However, there was no clear strategy on how this would be delivered. Staff felt supported by management but at times were unclear of whom to go to with issues. The practice had a number of effective policies and procedures to govern activity. Whilst the practice proactively sought feedback from patients they had had only limited success in this

Summary of findings

area and they had not been able to set up a patient participation group (PPG). All staff had received induction training and staff had regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice actively reviewed the care and treatment needs of older people. Each person who was over the age of 75 had a named GP. They kept up to date registers of patients' health conditions, those receiving palliative care, carers' information and whether patients were housebound. They used this information to provide services in the most appropriate way and in a timely manner. The practice was knowledgeable about the number and health needs of older patients using their service.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions Staff had a good understanding of the care and treatment needs of people with long-term conditions. The practice closely monitored the needs of this patient group. There were structured annual reviews to check their health and medication needs were being met and there was a process in place to make sure no patient missed their regular reviews for conditions, such as asthma, diabetes, respiratory and cardiovascular problems. Staff were skilled and regularly updated in specialist areas which helped them ensure best practice guidance was always being followed.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. There were comprehensive vaccination programmes which were managed effectively. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. All of the staff were very responsive to parents' concerns and ensured parents could readily bring children into the practice to be seen who appeared unwell. Appointments were available outside of school hours. Staff knew what to do if they had a concern about child protection and a GP was the lead for safeguarding and attended regular multi-disciplinary safeguarding meetings which included social workers and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of those groups had been identified and the practice had

Summary of findings

adjusted the services it offered to ensure they were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities and carers. The practice carried out annual health checks for people with learning disabilities and there was a process in place to make sure that patients attended. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health. The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medicines review. Patients were routinely and appropriately referred to counselling and other therapy services.

Summary of findings

What people who use the service say

As part of this inspection we had provided CQC comment cards for patients who attended the practice to complete. We received responses from 12 patients all were positive about the care they received and felt the doctors and nurses were caring and supportive. We spoke with ten patients during the site visit and they also told us they were happy with the care they had received and felt that all the staff treated them with dignity and respect.

The only less than positive comments on both the comment cards and from patients we spoke with were about the difficulty in getting appointments and the noise or lack of privacy in the reception area.

Areas for improvement

Action the service SHOULD take to improve

The provider should ensure that:

- regular checks are completed on emergency equipment.
- undertake audits in order to ensure effective infection control practice within the practice.
- engage patients about how the practice might improve.
- develop a strategic forward plan for the practice.

The Whitfield Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Whitfield Practice

The Whitfield Practice is situated in the Hunslet area of Leeds. It provides a range of primary care services including access to GPs, minor surgery, family planning, ante and post natal care to approximately 7700 patients from its surgery at the Hunslet Health Centre on Church Street Leeds. The practice does not provide its own out-of-hours services to patients. These are provided by the Leeds Primary Care Trust and can be accessed through the 111 service.

Overall the demographic of the patients at the practice are similar to the average for practices across England. However, the exception to this is the percentages of patients aged over 75 and 85, both of these are below the England average.

The practice has six doctors (equating to 4.24 whole time equivalents), five of whom are partners and one is a salaried GP. Of the six doctors four are female and two are male. The practice also has two female practice nurses and two health care assistants. There is also a practice manager, assistant practice manager, receptionists and secretarial staff.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Detailed findings

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We also reviewed policies, procedures and other information the service provided before and during the inspection. We carried out an announced visit on 15 October 2014.

During our visit we spoke with a range of staff including doctors, practice manager, practice nurses, health care assistant and reception and administrative staff. We also spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We also reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

We saw there was an incident reporting policy in place which outlined why incidents should be reported, how to report them and how they would be investigated. We spoke with staff and they were able to describe the incident reporting procedure and they discussed how action and learning plans were shared with all relevant staff. They confirmed that the practice had an open culture for reporting incidents and they looked at what happened, why it happened and what could be done to prevent it happening again.

The practice used information from different sources, including patient safety incidents, complaints and clinical audit to identify incidents that were occurring.

The practice had a record of the incidents that had occurred in the practice however they did not complete an annual review of all the incidents that had occurred in the practice each year, for example how many medicine related incidents or administration errors were occurring. There was no system in place to check if actions they had put in place to reduce the risk of incidents happening again were working.

Information from the Quality and Outcomes Framework (QOF) which is a national performance measurement tool showed that in 2012-2013 the practice was appropriately identifying and reporting incidents.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events. We saw evidence that internal investigations were conducted when any incidents occurred and staff confirmed that investigations were undertaken and changes made to prevent them happening again. For example when a patient had been prescribed a new medicine by a hospital consultant this was not picked up by the practice on the discharge notes. An investigation was completed and the protocol for managing patient information was updated.

Staff told us that if they were involved in an incident then they took part in the investigation and the lessons learned were disseminated. Staff told us the practice encouraged them to openly review the service and determine where they could improve.

We discussed the process for dealing with safety alerts with the practice manager. Safety alerts inform the practice of problems with equipment or drugs, or give guidance on clinical practice. They told us the alerts came into the practice via e-mail and they were disseminated by the practice manager to the GPs and nurses who checked to see if they were applicable to the practice. If it was, then any action required was taken. Staff confirmed they were made aware of relevant safety alerts. However, no written record of actions taken in response to safety alerts was available.

Reliable safety systems and processes including safeguarding

The practice had policies in place that set out how to identify potential safeguarding issues for both vulnerable adults and children. As well as detailing the signs to look for the policies also set out the action that should be taken.

The practice also had systems to manage and review risks to vulnerable children and adults. Staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their knowledge of safeguarding and staff were able to tell us about how they would recognise abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had a dedicated GP appointed as a safeguarding lead for vulnerable adults and children. They confirmed that they had received level three safeguarding training to enable them to fulfil this role. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. The GP also attended quarterly safeguarding meetings with the CCG. These meeting were found to be beneficial as information from other agencies such as schools was available.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example child protection reports were scanned onto the electronic patient record. The practice had a process for following up instances were

children persistently failed to attend appointments e.g. for childhood immunisations. It also followed up cases where older people either failed to request a repeat prescription or requested them too frequently.

A chaperone policy was in place and visible in the waiting room, in consulting rooms and also in the practice handbook. The practice nurses had received chaperone training and would normally act as chaperones. If they were not available two of the receptionists had also undertaken training and understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence of significant events that had been investigated where errors or omissions had occurred in the scanning of documents and that action had been taken to address the shortcomings identified.

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 medicines were kept at the required temperatures and records were kept of these checks. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

Processes were in place to check medicines were within their expiry date and suitable for use. The medicines, with the exception of those in the emergency drugs box and the GP's bag we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to reviews of prescribing data. For example, was reviewing the treatment of patients with atrial fibrillation as it had a lower than average number of patients who received treatment with anticoagulants or antiplatelet drugs. The minutes of the partners meeting confirmed that medicine management issues were regularly discussed.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

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.

Cleanliness & Infection Control

During the inspection we spoke with the practice manager, nursing staff and reception staff about infection prevention and control (IPC) in the practice. The staff we spoke with were able to describe the measures they took to prevent the spread of infection. This included washing their hands before and after dealing with patients, regular washing and wiping down of equipment and work surfaces, and wearing personal protective equipment (PPE). Staff told us there was PPE available for them to use, including masks, disposable gloves and aprons. We saw that hand wash; disposable towels and hand gel dispensers were also readily available for staff. We observed that there was hand gel in the waiting area for patients to use. Staff told us that there had been no training on infection prevention and control in the last 18 months.

We looked around the waiting area, the consultation and treatment rooms and found these were clean and tidy. The practice manager explained that domestic staff cleaned the practice at the end of each day and clinical staff were responsible for ensuring that consultation and treatment rooms were kept clean between consultations.

Cleaning schedules were in place outlining which areas were cleaned daily, weekly and monthly. Best practice guidelines for cleaning were being followed therefore reducing the risk of cross-infection. Feedback from patients said that the practice was clean. Patients were cared for in a clean environment.

Good

Are services safe?

Sharps bins were appropriately located, labelled, closed and stored after use. There was a contract in place for the removal of all household, clinical and sharps waste and we saw evidence that waste was removed by an approved contractor.

Staff we spoke with told us that all equipment used for minor surgery was single use. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We saw that other equipment used in the practice was clean.

Infection prevention and control procedures had been developed which provided staff with guidance and information to assist them in minimising the risk of infection. However, there was no nominated lead for IPC within the practice who was responsible for ensuring good practice was followed. IPC audits were undertaken by the Leeds Community Healthcare NHS Trust. However no audit had been carried out since September 2012. The practice did not independently monitor the standards of cleaning provided and did not have copies of the IPC audit, so any areas for improvement could not be identified and actioned.

The GP told us that clinical staff had received the immunisations required for working in a GP practice, this included Hepatitis B. Staff had had their immunisation status checked which meant the risk of staff transmitting infection to patients was reduced. They told us how they would respond to needle stick injuries and blood or body fluid spillages and this met with current guidance. We saw details of a serious event analysis following a needle stick injury which confirmed that the correct action had been taken. A spillage kit was available for staff to use in the event of blood or body fluid spillages.

Legionella testing had been carried out by the Leeds Community Healthcare NHS Trust at quarterly intervals.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We looked at a sample of medical equipment throughout the practice and other electrical equipment and saw they had been serviced as required. We saw records showing that equipment, such as the fridges containing medicines and digital blood pressure monitors, had been serviced and maintained at required intervals by competent persons. These measures provided assurance that the risks from the use of equipment were being managed and people were protected from unsafe or unsuitable equipment.

Staffing & Recruitment

The practice had both male and female GPs and practice nurses and healthcare assistants as well as a number of administrative/reception staff which ensured that the needs of patients could be met. The practice provided details to their patients of their staffing levels on their website.

The provider had a recruitment policy in place which outlined the process for appointing staff, and the pre-employment checks that should be completed for a successful applicant before they could start work in the practice. As most of the staff had been with the practice for a number of years their recruitment files were not available for us to review, We did however review the recruitment details for a recently employed member of staff and this reflected the current recruitment policies.

There was no process in place to check that doctors and nurses were meeting the requirement to remain registered with their professional bodies such as the General Medical Council and the Nursing and Midwifery Council, and therefore were still deemed fit to practice.

Monitoring Safety & 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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example the practice monitored repeat prescribing for people receiving medication for mental health needs to check for patients who failed to request a repeat prescription or requested renewals too frequently.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We were told that staff had received training

Good

Are services safe?

in basic life support. However, the detailed records of what training staff had undertaken were not kept centrally. Some were recorded on the practices IT system and some staff kept their own training records.

Emergency equipment was available including access to oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). Staff knew the location of this equipment and confirmed their understanding of what action they would take in the event of a medical emergency concerning a patient. There were no records kept to confirm that the oxygen cylinder and defibrillator where checked regularly. The paediatric defibrillator pads were out of date. The practice were aware of this and told us that they would use adult pads in an emergency. In addition the oxygen cylinder did not have tubing attached or a mask for adult use, only for a child. This was addressed by the practice when we brought it to their attention.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Whilst processes were in place to check emergency medicines were within their expiry date and suitable for use we found one of the medicines, cortisone sodium phosphate was passed its expiry date of July 2014 However records showed that the emergency medicines box had been checked in September 2014 and the expired medicines had not been removed. One of the GPs bags also contained adrenaline which had an expiry date of May 2014.

The practice must take steps to ensure that all emergency medicines and equipment are fit for purpose and safe to 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. 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. A fire risk assessment had been undertaken that included actions required to maintain fire safety and regular fire alarm testing and drills were undertaken.

Good

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 treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. New guidelines were disseminated electronically by the practice manager. We were told that any changes that impacted on the practice or their patients were discussed and appropriate actions taken. Staff we spoke to demonstrated knowledge about guidance from local commissioners and NICE.

Staff described how they carried out comprehensive assessments which covered health needs. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example the practice was reviewing the case notes and treatment for patients with atrial fibrillation as it had a lower than average number of patients who received treatment with anticoagulants or antiplatelet drugs.

The GPs told us they lead in specialist areas such as prescribing and ensured that other GPs and nursing staff were aware of and followed local and NICE guidance. The practice was prescribing a higher than average amount of tramadol and actions were being taken to reduce this. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

The practice had a process in place for reviewing the information received on patients recently discharged from hospital. The information was scanned into the patient record and sent to the named GP for review. In addition a nominated GP looked at all A&E discharge summaries to ensure attendances had been coded correctly and important information documented.

National data showed the practice was in line with emergency attendance or admission rates for cancer and dementia. The GPs we spoke with used national standards for the referral of patients for example those with suspected cancers, who were referred and seen within two weeks. We saw minutes from meetings which demonstrated that all clinical staff discussed new pathways that were being introduced, for example for gastroenterology.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making. Feedback from patients confirmed that they were referred to other services or hospital as required.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling and medicines management. The information staff collected was then collated by the practice identifying where clinical audits were required. Examples of clinical audit included: audit of patients receiving antibiotics for urine infection; amber drug audit; audit of patients diagnosed with cancer as a result of an acute admission and an audit of patients with abnormal liver function test results. There was evidence that the results of audits had been discussed with the GPs in the practice with learning points identified and improvements in patient care had been demonstrated. However the practice nurses were not routinely involved in audits.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of Quality and Outcomes Framework (QOF) performance. QOF is a national performance measurement tool. For example we saw an audit regarding the prescribing of antibiotics for urine infections. The results of the audit led to a change in antibiotic prescribing for patients in nursing homes and also the GPs did further learning around the topic as part of their continuing professional development. This was shared with clinical staff.

The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The QOF

Good

Are services effective?

(for example, treatment is effective)

information showed the practice was effectively supporting patients with conditions such as asthma, diabetes and heart failure. The practice was not an outlier for any QOF, or other national clinical targets.

The nurse we spoke with told us that they did not have formal clinical supervision sessions. However they attended a meeting every two months with nurses from other practices in the locality where they had the opportunity to discuss their clinical practice. They told us it felt like group supervision. They also said they could discuss their clinical practice at any time with the GP. All the staff we spoke with said they felt supported in their role and they felt confident in raising any issues with the practice manager or the GP.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and followed up with patients who had not attended appointments.

Effective staffing

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

The nurses in the practice were registered with the Nursing and Midwifery Council (NMC). To maintain their registration they must undertake regular training and updating of their skills. The GPs in the practice were registered with the General Medical Council (GMC) and were also required to undertake regular training and updating of their skills.

All staff undertook annual appraisals and interviews with staff confirmed that the practice was proactive in providing training and supporting professional development.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, administration of vaccines and cervical cytology. Those with extended roles such as seeing patients with diabetes and coronary heart disease demonstrated that they had appropriate training to fulfil these roles.

Whilst there was evidence of staff training, including attending mandatory courses such as annual basic life support. It was not possible to establish the exact details of what training staff had received as the information was not kept in one central record. Whilst some information was recorded on the practices IT system, other details such as attendances at some training courses was held by staff themselves and this was not available to us on the day of our inspection. However staff said that they were supported and received appropriate training to help them deliver effective care to patients.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, x ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. Staff in the practice were able to demonstrate who had responsibility for recording and actioning any issues identified in communications from other care providers on the day they were received. It was the responsibility of the named GP or in their absence the duty GP to review these documents and to ensure relevant action was taken.

The practice held quarterly multidisciplinary team meetings to discuss patients with complex needs such as those receiving palliative care and decisions about care planning were documented in a shared care record. Minutes from meetings confirmed that community nurses, health visitors, palliative care nurses and social workers attended to discuss treatment and care and ensure it was meeting the needs of patients. Practice staff described how they worked with the community nursing and health visiting teams to ensure patients received appropriate and timely care

Information Sharing

Electronic systems were also in place for making referrals as the practice used the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

The practice had signed up to the electronic Summary Care Record (Summary Care Records provide healthcare staff

Good

Are services effective?

(for example, treatment is effective)

treating patients in an emergency or out-of-hours with faster access to key clinical information). Details of this were provided to patients in the practice handbook and on the website.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. The staff in the practice used the scanning facility in the system to attach electronic copies of paper documentation, for example discharge information received from hospitals. There were processes in place to ensure that all documents were scanned into the patients' record in a timely manner and reviewed by the GP.

Consent to care and treatment

We found that processes were in place to seek and record patients' consent and decisions were made in line with relevant guidelines. Staff we spoke with were able to describe the consent process and demonstrated a good understanding of the Mental Capacity Act 2005 in relation to consent. Capacity assessments and Gillick competency assessments of children and young people, which check whether children and young people have the maturity to make decisions about their treatment, were part of clinical staff practices. Reference to the Gillick competency assessments were included on the treatment consent form. Staff told us they explained procedures to patients and checked their understanding before any treatment was carried out.

The practice documented consent for specific interventions such as all minor surgical procedures where written consent was taken. Where verbal consent was taken, for example with baby vaccinations this was recorded in the template on the patient record. As part of recording consent the GPs and nursing staff would ensure that the patients were aware of the relevant risks, benefits and complications of the procedure.

Health Promotion & Prevention

The practice offered all new patients a consultation to assess their past medical histories, care needs and assessment of risk. If any issues were identified these were followed up by the GP in a timely manner. Any new patients between 40 and 74 were placed on the NHS Health Check programme. Patients over 75 all had a named GP.

Each of the GPs had responsibility for residents in a specific care home in the area and made routine visits to check on their health needs.

We saw the practice took steps to identify which patients attending the practice had a caring role and there was information about carers support groups available in the waiting area for patients.

There was a good range of health promotion information in the waiting room and on the practice web site. We saw that there were posters around the practice promoting services that may help support patients, such as smoking cessation and support with mental health. The practice also offered a weekly clinic offering support and advice on issues around alcohol dependency.

The practice offered annual reviews for people with long term conditions such as diabetes, asthma and cardio vascular disease. The practice had a number of ways identifying patients who needed additional support. For example, the practice kept a register of all patients with learning disabilities and patients receiving palliative care. These groups were offered support and care in line with their needs. There were also processes in place for patients in these groups to ensure that regular reviews were undertaken and prescriptions were requested as needed.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The percentage of patients aged 65 and older who received a seasonal flu vaccination last year was above the national average.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction based on information from the national patient survey. This showed that the practice was in line with the national averages for patients rating the practice as good or very good and ratings for both doctors and nurses as good or very good for treating them with care and concern. The practice also sent surveys to its patients, however, only six patients responded. All of these responses showed patients were satisfied with the care received. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

Staff we spoke to were aware of the need to treat all patients irrespective of their circumstances with sensitivity and respect. This included people in vulnerable circumstances for example those with no fixed address or those experiencing poor mental health.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 12 completed cards and the majority of the comments were positive about their experience of the service. Patients said they felt that staff treated them with compassion, dignity and respect. There were comments on two of the comment cards about the difficulty in getting appointments. We also spoke with 10 patients on the day of our inspection. Overall they were satisfied with the care provided by the practice; however they also mentioned the difficulty in getting appointments.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We observed that curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

The practice had an open plan reception area, which was shared with another practice and community services provided in the same building. Phone calls from patients were taken away from the reception desk which helped to keep patient information private. We observed that staff were discrete and quiet when speaking with patients and tried to ensure that conversations were conducted in a confidential manner. We were told that patients could if they wished ask to speak to a receptionist in private. We did observe one incidence of a receptionist giving full details of blood results to a patient and the details of the conversation could be heard in the seating area in reception.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients were satisfied with their involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed that the practice was ratings were above the national average when asked if the nurse was good or very good at involving them in decisions about their care.

The patients we spoke to on the day and the feedback on the comments cards demonstrated that patients felt involved in decision making about the care and treatment they received.

Staff told us that translation services were available for patients who did not have English as a first language. This information was also available on the practice website. In addition one of the receptionists could speak three eastern European languages, which covered some of the languages of the practices ethnic minority patients. The practice could also arrange for interpreters if needed. There were also notices in the reception areas informing patients of how interpretation services could be accessed.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed that patients thought the practice were positive about the emotional support provided by the practice and rated it as acceptable in this area. Three of the patients we spoke to commented on how supportive the practice had been in helping them deal with bereavement or accessing support from mental health services. Comment cards we received were also consistent with this survey information.

Notices in the patient waiting room signposted people to a number of support groups and organisations including breast cancer screening and mental health support groups. The practice also asked patients to notify them if they were a carer and this was recorded on their patient record on the practice's computer system. Carers were also told that if they wished they could be referred to Carers Leeds for further advice and support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs. However, they did highlight the lack of engagement with patients as a concern. We discussed this area with staff at the practice and they explained the number of ways that they had tried to gain engagement from their patients. This included trying to establish both an actual, and when this did not generate any interest, a virtual Patient Participation Group (PPG). However, despite trying to generate interest by displaying posters in the surgery, giving out leaflets, placing requests on repeat prescriptions and in new patient registration packs no one volunteered. As there is no formal mechanism in place to capture the views of patients staff at the practice are aware of the need to respond to views or comments made in more informal ways, for example in comments made to receptionists, nurses or doctors. For example when patients comment on the difficulty of getting through to the practice on the telephone they introduced an additional telephone line.

There had been very little turnover of staff during the last three years which has enabled good continuity of care. Patients could get appointments with named GP but may have to wait for an appointment with a specific GP. However, all of the patients we spoke to and all of the comment cards completed were very complimentary about the quality of care received from the GPs and nursing staff.

The practice had achieved and implemented the gold standards framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. It had access to online translation services and one of the reception staff spoke three eastern European languages including Polish, which was the most common language for the patients who did not have English as their first language. Information could also be obtained in a wide range of other languages and formats.

The practice provided equality and diversity training. Staff we spoke with confirmed that they had undertaken the training in the last twelve months.

The practice was accessible to patients with mobility difficulties there was step free access to the building and other facilities were all on one level. The consulting rooms were accessible for patients with mobility difficulties and there was also an accessible toilet. There was a large waiting area with plenty of space for wheelchair users. There was a hearing loop in reception and two of the reception staff had basic British Sign language skills.

Access to the service

We found that patients could make their appointments in different ways, either by telephone, face to face or online, via the practice website. Patients who did not need an urgent appointment could book them in advance which freed up slots for patients who needed to be seen quickly.

The practice was open from 8.00am until 6.30pm from Monday to Friday with extended opening times on Tuesdays and Thursdays. It stayed open until 7.00pm on a Tuesday and opened at 7.00am on a Thursday. The practice also provided telephone consultation appointments. Patients who worked during the day or were unable to get to the practice had a choice of how they made their appointment and how and when they wanted to see the GP or nurse. The extended opening times also ensured that appointments were available outside of school hours for children and young people.

Patients we spoke with and feedback from CQC comment cards highlighted that that there were some problems with patients getting appointments. Although generally emergency appointments were available on the day but it was difficult to get through to the practice to book one. To try and address these issues the practice was trialling offering five minute emergency appointments. Patients we spoke to on the day of our inspection felt that the emergency appointment approach had made access easier. However the new system had not been communicated to all patients in a formal way.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We also found that patients could order repeat prescriptions on line, in person or by telephone. This meant the practice was using different methods to enable patients' choice and ensure accessibility for the different groups of patients the practice served.

We saw information displayed in the waiting area and on the practice web site about what to do in an emergency, in hours and out of hours.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Information on how to make a complaint was on the practice website, in the patient information leaflet and displayed in the waiting room. This included information of who to contact to make a complaint and the timescales they would receive a response by.

Patients we spoke with told us they were not aware of the complaints procedure but if they were not happy with something they would raise it with a member of staff. Staff we spoke with told us they were aware of the practice complaints policy and would direct patients to the practice manager.

The practice had received 10 complaints in the previous 12 months. We saw details of the complaints received and the action taken. The complaints were also categorised so that recurring areas of complaint could be identified. Complaints were discussed at the GP partners meeting. However, there was no process in place to ensure that the learning from complaints or trends in complaints was discussed with all staff.

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 set out its vision on the practice website as wanting to "provide the highest standards of patient care". All staff we spoke to were committed to providing good patient care. In the statement of purpose provided to CQC it stated that the practice ethos was to "strive towards a partnership between patients and health professionals based on mutual respect, holistic care and continuity of care. However, the practice did not have a strategy document or strategic plan outlining how the vision was going to be achieved. There was no evidence that the details in the statement of purpose were shared with patients or that they were discussed or progress reviewed regularly by staff.

Governance Arrangements

The practice had a clinical governance policy and one of the GPs was the lead for governance. There were policies for key areas of practice, for example handling significant events, infection control and safeguarding policies for adults and children and these supported staff to deliver high quality care.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. Performance was discussed at practice meetings. Data from various sources such as, incidents, complaints and audit to identify areas where improvements could be made. We saw evidence where practices, such as in prescribing, had been changed as a result.

The practice had systems to identify, assess and manage risks related to the service. There was a health and safety policy and a comprehensive business continuity plan was in place.

Procedures were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. The results were discussed at practice meetings and if necessary changes were made to the practice's procedures and staff training. All of the systems we reviewed showed that the practice was monitored. The practice also carried out audits to monitor the quality of services provided. For example one of the GPs had used prescribing information and national alerts to review the medication they prescribed. This helped to ensure patients were receiving the most appropriate medication in line with best practice.

Staff told us they felt confident about raising any issues and felt that if incidents did occur these would be investigated and dealt with in a proportionate manner.

Leadership, openness and transparency

There was clarity about who was leading in certain areas such as governance, safeguarding and prescribing. While we did not identify any issues of concern with respect to infection control matters, we noted that there was no identified person within the practice to take a lead on this issue in order to provide continual assurance that risks on infection were minimised.

Staff told us that they were clear about their own roles and responsibilities and that they felt valued and supported. We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or individually outside of the meetings.

Practice seeks and acts on feedback from users, public and staff

The practice had tried to gather feedback from patients through patient surveys and by trying to set up a patient participation group. However, they had not been able to get patients actively involved with the practice. When patients did express their views or concerns, for example to the nurse, GP or receptionist these were considered and actioned. For example the practice had added an additional telephone line when patients had raised concerns about being unable to contact the practice.

The practice had not routinely gathered feedback from staff through a staff survey, however, staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. There was a whistle blowing policy in place which informed staff of how they could raise concerns within the practice and with external organisations.

Are services well-led?

Good

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

Management lead through learning & improvement

The practice ensured that staff had access to learning and improvement opportunities. Newly employed staff had a period of induction to support them. On-going peer support and formal appraisals were evident.

Staff told us they had access to training. The practice had protected learning time for training and development.

The GPs had regular meetings as did the nursing and administrative staff. Every Tuesday the GPs met to discuss findings from audits and significant event analysis. Other clinical staff only attended this meeting every two months. For the meeting that they did not attend any changes to practice were disseminated through the practice manager. Whilst nursing staff were able to discuss any clinical issues with the GPs on an ad-hoc basis they only had limited access to meetings where clinical developments were reviewed and discussed.