Dr Kieran Pressley

Quality Report

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 3

The six population groups and what we found 5

What people who use the service say 7

Areas for improvement 7

Detailed findings from this inspection

Our inspection team 8

Background to Dr Kieran Pressley 8

Why we carried out this inspection 8

How we carried out this inspection 8

Detailed findings 10

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the practice of Dr Kieran Pressley on 19 May 2015. Overall the practice is rated as good.

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

Our key findings were as follows:

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

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

- Ensure all staff have a formalised annual appraisal and a personal development plan in place.
- Ensure all staff acting in the capacity of a chaperone have appropriate training.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, to report incidents and near misses. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed, care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. Although staff had appraisals, these were not done on a formal basis using a structured framework. Staff had received training appropriate to their roles and they worked with multidisciplinary teams to provide effective care and support to patients.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Sheffield Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a preferred GP, there was continuity of care and urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. Learning from complaints was shared with staff.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures in place and held regular practice meetings. There were systems in place to monitor and improve quality and identify risk. Staff received induction, regular performance reviews and attended staff meetings. The practice proactively sought feedback from patients and staff which it acted upon.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. All patients over 75 years of age had a named GP. The practice was responsive to the needs of older people, offering home visits and longer appointments. The practice worked closely with relevant health and social care professionals to deliver a multidisciplinary package of care.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The GPs and nursing staff had lead roles in chronic disease management such as diabetes and chronic obstructive pulmonary disease (COPD). There were structured annual reviews in place to check the health and medication needs of patients were being met. Longer appointments and home visits were available when needed. Staff worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. The practice provided sexual health support and contraception, maternity services and childhood immunisations. Data showed immunisation uptake rates were above average for Sheffield Clinical Commissioning Group (CCG). Appointments were available outside of school hours and the premises were suitable for children and babies. Same day appointments were available for all children under the age of 16 years.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). Although the practice did not have extended hours they would offer appointments at the end of surgery to accommodate patients who could not attend during normal surgery hours. There was a full range of health promotion and screening which reflected the needs of this population group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. These patients were offered an annual health check and longer appointments were available where required. There was access to translation services for people who were non-English speaking. Additional services were available for patients who had a hearing or visual impairment.

The practice advised vulnerable people how to access various support groups and voluntary organisations. It regularly worked with multidisciplinary teams, such as substance misuse or counselling services, in the case management of vulnerable people.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health, including people with dementia. The practice offered annual health reviews, longer appointments and home visits as needed for all patients within this population group. The practice informed patients how to access various support groups and voluntary organisations. For example, signposting patients to the Improving Access to Psychological Therapies (IAPT) team, who could offer counselling, support and advice as appropriate.

Summary of findings

What people who use the service say

We received 48 CQC comment cards where patients shared their views and experiences of the practice. All the comments on the cards were positive and complimentary. Many citing the staff as being caring, polite and treating them with dignity and respect and the service they received as being 'excellent'. There were several very complimentary comments which specifically identified individual practice staff.

We also spoke with 12 patients on the day of our inspection. These patients covered a range of ages and population groups. All were positive about the practice and told us they were listened to, felt support and were treated with dignity and respect. The majority of patients were complimentary about the appointment system and said they received a same day appointment if needed. We observed patients didn't have to wait long from the time of their appointment to the clinician seeing them.

We looked at the National Patient Survey (January 2015), which had sent out 246 questionnaires and 103 responses had been returned (a 42% completion rate). Eighty nine percent of respondents said they usually got to see/speak with their preferred GP. This was significantly higher than the CCG average of 58%. In addition, 99% of respondents said they had confidence and trust in the last GP they saw or spoke with.

The practice had made numerous attempts to form a Patient Participation Group (PPG) unfortunately there had been no uptake from their patients. They had undertaken their own patient survey in relation to the appointment system. Of the responses they had received, the majority were satisfied with the appointments and access to the doctor of their choice. Less than 3% of responses said they were not satisfied with the appointment system.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all staff have a formalised annual appraisal and a personal development plan in place.
- Ensure all staff acting in the capacity of a chaperone have appropriate training.

Dr Kieran Pressley

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Kieran Pressley

Dr Kieran Pressley's practice is also known as Totley Rise Medical Centre. It is part of Sheffield Clinical Commissioning Group (CCG) and is located in one of the lesser socially deprived areas of Sheffield.

The practice provides General Medical Services (GMS) for a population of 3174 patients under a contract with NHS England. They are registered to provide the following regulated activities: treatment of disease, disorder or injury; family planning; maternity and midwifery services; diagnostic and screening procedures.

The practice has a male GP and two salaried female GPs. In addition, there are two female practice nurses and a healthcare assistant. The clinical team are supported by an experienced practice manager and team of administration and reception staff.

The practice opening times are Monday to Friday 8.30am to 6pm, with the exception of Thursdays when the practice closes at 1pm. Patients can access the appointment system in person at reception, by telephone or online via the practice website. Some appointments are pre-bookable and others are bookable on the day. The practice also offers same day appointment for urgent cases. When the practice is closed, out of hours cover for emergencies is provided by NHS 111 and the Sheffield GP Collaborative.

Why we carried out this inspection

We carried out a comprehensive inspection of the services 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 registered 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 or data throughout this report, for example any reference to the Quality and Outcomes Framework or GP Patient Survey, this relates to the most recent information available to CQC at that time.

How we carried out this inspection

Before visiting the practice we reviewed information we hold about the practice and asked other organisations, such as NHS England Local Area Team and Sheffield Clinical Commissioning Group, to share what they knew.

We carried out an announced inspection visit at Dr Kieran Pressley's practice based at Totley Rise Medical Centre on the 19 May 2015. During our visit we spoke with a range of staff, including two GPs, the practice manager, two practice nurses and a receptionist. We also spoke with 12 patients who used the service.

Detailed findings

We observed communication and interactions between staff and patients, both face to face and on the telephone within the reception area. We reviewed 48 CQC comment cards where patients had shared their views and experiences of the practice. We also reviewed documents relating to the management of the practice.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included reported incidents, national patient safety alerts, clinical audits, comments and complaints received from patients.

The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. They informed us incidents and complaints were raised and discussed at the practice and staff meetings. The practice manager told us they also provided individual feedback to the member of staff who reported an incident. They would also send out a memo to all staff identifying any actions or learning which had arose from the incident.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events which had occurred during the last twelve months and saw the system was followed appropriately. Staff both verbally reported and completed incident forms which were assigned to the practice manager to investigate. The practice manager told us they would also liaise with the GP to discuss any actions which may need to be taken.

Both clinical and non-clinical staff gave us examples of reported incidents, the actions the practice had taken and the learning points. For example, a clinician had left the room where the patient was and had left their smart card in the computer (each member of staff is issued an individual smart card which allows a secure and authorised access to the practice's electronic record system). The practice had identified learning from this incident and ensured all clinical staff were aware to take the necessary security precautions when leaving the room.

National patient safety alerts were disseminated by the practice manager to all staff, who signed to say they had seen them. Staff we spoke with were able to give examples of recent alerts which were relevant to the care they were responsible for. We were informed alerts could also be disseminated by Sheffield Clinical Commissioning Group (CCG) and at local learning events.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and adults whose circumstances may make them vulnerable. Staff we spoke with were aware of their responsibilities and knew how to share information, record safeguarding concerns and how to contact the relevant agencies in both working hours and out of normal hours. We saw safeguarding policies and procedures were available and easily accessible for all staff. Although we saw there were posters detailing contact details of relevant agencies for children's safeguarding, we did not see any visible evidence of contact details specifically for adult safeguarding. The practice manager has since informed us contact details for all agencies are now available in all the consulting rooms and administration area.

The practice had a designated lead for safeguarding vulnerable adults and children, who had completed level 3 safeguarding training. All staff we spoke with were aware of who the lead was, what they would do if they encountered a safeguarding concern and who to speak to in the practice. The practice manager informed us all staff were up to date and had role specific children and adults safeguarding training every two years through the local practice learning events; the next one was due in July 2015.

There was a system in place to highlight vulnerable patients on the practice electronic records. This included information to make staff aware of any relevant issues when patients attended for appointments. For example, children who were subject to child protection plans. The practice held monthly meetings with other health professionals, such as the health visitor, to discuss concerns and share information about children and vulnerable patients registered at the practice.

There was a chaperone policy in place and a poster displayed in the reception area alerting patients to the availability of a chaperone if required. 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. Both nursing and some reception staff acted in the capacity of a chaperone. Although not all staff who might be asked to undertake chaperone duties had received specific chaperone training, they could explain

their responsibilities when undertaking this role, including where to stand to be able to observe the examination. The practice manager has since informed us chaperone training has been organised for all appropriate staff to attend.

Medicines management

We checked medicines stored in the treatment rooms and vaccine refrigerators. We found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring medicines and vaccines were kept at the required temperatures. Staff told us the procedure was to check the refrigerator temperatures on a daily basis. We saw evidence of daily records being kept. Processes were in place to check medicines and vaccines were within their expiry date and suitable for use. We checked the refrigerators where vaccines were stored. The sample of medicines and vaccines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Requests for repeat prescriptions were taken in person at the reception desk, by post or over the internet. Administration/reception staff told us the checks undertaken prior to dispensing a prescription. For example, name, address, date of birth of the patient and the medication requested. All prescriptions were reviewed and signed by a GP before they were issued. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

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

An infection prevention and control (IPC) policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Personal protective equipment including disposable gloves and aprons were available for staff to use. Hand washing sinks with hand soap, antibacterial gel and hand towel dispensers were available in treatment rooms. Sharps bins were appropriately located and labelled. The practice had access to spillage kits to support the safe and effective clean-up of bodily fluid spillages, for example blood or vomit.

There was a lead for IPC and all staff had recently had IPC training in March 2015. The IPC lead told us they had recently provided additional training to reception staff regarding handling samples such as blood and urine.

We were shown the latest IPC audit, which had been undertaken in April 2015. There was an action plan and the practice manager confirmed what actions had been implemented. It was identified the practice required a risk assessment to be undertaken for legionella (a bacterium which can contaminate water systems in buildings). The practice manager informed us a date for legionella testing had been organised.

Equipment

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

Staffing and recruitment

The practice had a recruitment policy setting out standards it followed when recruiting clinical and non-clinical staff. We looked at two staff files and confirmed pre-employment checks were in place in line with the practice policy. For example, proof of identification, references and qualifications. The majority of staff had worked at the practice for many years and there had been no recently recruited staff in the past twelve months. The practice manager informed us they had arranged for all staff to have an up to date Disclosure and Barring Service (DBS) check.

Staff told us about the arrangements for planning and monitoring the number and mix of staff required by the practice to meet the needs of patients. They told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager told us how they had recently reviewed the number of practice nurse hours and, as a result, they were advertising for another practice nurse.

Good

Are services safe?

There was an arrangement in place for non-clinical staff to cover each other's annual leave and sickness. We were informed locums were used for GP cover if necessary, generally using the same locum to support continuity of care and consistency. There was a locum induction pack which was utilised as required.

Monitoring safety and responding to risk

The practice looked at safety incidents and concerns raised and identified how they may have been avoided. They also reported to external bodies such as NHS England and Sheffield CCG in a timely manner.

The practice had arrangements for monitoring safety and responding to changes in risk to keep patients safe. The GP and practice manager told us they would regularly do a practice walk round to look at and identify any potential areas of risk. For example, the condition of flooring and security of the premises. Although they had assessed any potential fire risk or hazards, the practice did not have a formal fire risk assessment in place. The practice manager has since informed us a formal fire risk assessment is being undertaken by an outside agency.

Risks were discussed at practice meetings and within team meetings. Staff were encouraged to report any potential risks.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Members of staff knew the location of this equipment and how to use it. Records showed all staff had received training in basic life support. The practice manager gave us an example where staff had assisted someone in an emergency. The person had come into the practice and informed staff they were going to have a seizure (as they had epilepsy) but they did not require an ambulance. The staff ensured the person was safe and contacted one of the GPs who checked the person was medically fit to eventually leave the practice after the seizure.

Emergency equipment and medicines were available in a secure area of the practice. Staff told us these were checked on a daily basis and we saw records confirming this. We checked the equipment and medicines at the time of inspection and found all medicines were in date and the equipment was fit for use.

A business continuity plan was in place to deal with a range of emergencies which may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Identified risks included power failure, loss of premises and loss of telephone systems. The document also contained relevant contact details for staff to refer to, for example the utility company if power was lost. There was also an emergency box kept in the reception area which contained various equipment should there be a power failure. For example, a torch, candles and a mobile phone. The box was checked regularly to ensure the mobile phone was charged.

The practice had a 'buddy' system in place with local practices where they could access the computer systems securely using their smartcards and a central computer back up system.

There were arrangements in place to protect patients and staff from harm in the event of a fire. For example, fire equipment checks and fire drills were undertaken. All staff had received fire safety training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with best practice guidance. They accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told new guidelines were disseminated, the implications for the practice's performance and patients were discussed and any actions agreed at the practice's weekly meetings. 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 as appropriate.

The GPs told us they had a lead in specialist clinical areas such as diabetes, heart disease and palliative care and the practice nurses supported this work. This allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. We were told this supported all staff to review and discuss new best practice guidelines. For example, for the management of chronic obstructive pulmonary disease (COPD).

The practice had registers for patients who had a long term condition or required palliative care. Patients had their condition reviewed and monitored using standardised local and national guidelines. We were shown templates the clinicians used to manage conditions such as asthma and chronic obstructive pulmonary disease (COPD). Additionally, palliative care meetings were held and included other health professionals who were involved in individual patient's care, for example members of the district nursing team and palliative care nurses.

The nursing staff we spoke with told us they used personalised self-care management plans with patients as appropriate, raised awareness of health promotion and referred/signposted to other services when required. The practice nurses told us how they supported patients and referred them to other services, such as podiatry and DESMOND (diabetes education and self-management for ongoing and newly diagnosed); which was a local diabetic education programme.

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

Management, monitoring and improving outcomes for people

Information about patients' care, treatment and their outcomes was routinely collected and monitored. This information was used to improve patient care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits and other improvements to the service.

Information collected for the quality and outcomes framework (QOF) and performance against national screening programmes was used to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures. The practice was at or above average for many of the QOF domains, particularly in dementia, depression and epilepsy.

The practice had a system in place for completing clinical audit cycles. We were shown four clinical audits which had been completed within the past twelve months. Following each clinical audit, changes to treatment or care had been made where needed and the audit repeated to ensure outcomes for patients had improved. Examples of clinical audits included a review of the management of patients prescribed thyroxine (a medicine used in the treatment of thyroid disorders) and the impact of induced osteoporosis in patients who are prescribed prednisolone.

In addition, the GP had also undertaken a recent audit of novel oral anticoagulant (NOAC) prescribing after revised NICE guidance had been published for Atrial Fibrillation (AF); a heart condition which can cause an irregular and abnormal heartbeat. These medicines had been recently approved by NICE for use in patients who have AF as an

Good

Are services effective?

(for example, treatment is effective)

alternative to warfarin for the prevention of stroke and embolisms. This supported evidence the GP was following NICE guidance effectively and prepared to consider new treatment options to improve patient care.

Effective staffing

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

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

Practice nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. The practice nurses were registered with the Nursing and Midwifery Council (NMC). To maintain registration they had to complete regular training and update their skills. The nurses we spoke with confirmed their professional development was up to date and they had received training necessary for their role. The practice manager told us the procedure they had for checking all clinical registrations.

Although staff had appraisals, these were not done on a formal basis using a structured framework which included a personal development plan. We were informed at the time of the inspection that procedures would be put in place to ensure all staff had annual appraisals and a personal development plan using a formalised approach. All the staff we spoke with told us they were supported to attend any training relevant to their role and they had access to the practice manager and GPs if they had any issues or concerns.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those patients with complex needs. It received blood test results, X-ray results, letters and discharge summaries from other services, such as hospitals and out-of-hours services (OOHs), both electronically and by post. All staff we spoke with understood their roles and responsibilities when processing the information. There were systems in place for these to be reviewed and acted upon where necessary by clinical staff.

The practice held monthly multidisciplinary team (MDT) meetings to discuss the needs of patients with complex needs. For example, those with multiple long term conditions, mental health problems, end of life care needs or patients who were vulnerable or at risk. These meetings were attended by a range of health and social care staff, such as health visitors, social workers and members of the district nursing team.

Information sharing

The practice used electronic systems to communicate with other providers. There was a shared system with the local GP out-of-hours (OOH) provider to enable patient data to be shared in a secure and timely manner. We were told information regarding patients who had complex health conditions was faxed securely to the OOH provider. For example, those who were on an end of life care pathway and/or had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place. This was to ensure continuity of care and avoid any unnecessary distress to patients.

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

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

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 and Children Acts 1989 and 2004. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Some staff gave us examples where they had identified an issue, the action they had taken and how they had recorded it on the patient's record.

Good

Are services effective?

(for example, treatment is effective)

Staff told us they spent time discussing treatment options and plans with patients and were aware of consent procedures. They explained discussions were held with patients to assure their consent prior to treatment. The GPs gave us examples of how a patient's best interests were taken into account if a patient did not have the capacity to make a decision.

All clinical staff we spoke with demonstrated a clear understanding of Gillick competency assessment. These assessments are used to check whether a child under 16 has the maturity and understanding to make their own decisions about their treatment. We were told how consent and competency assessments were recorded in a patient's records.

Health promotion and prevention

The practice was involved with national breast, bowel and cervical cytology screening programmes. Follow up of non-attenders was undertaken by the practice. The practice's performance for cervical smear uptake was comparable to other practices in the area.

They offered NHS checks to all patients aged 40 to 75 years. We were shown the process for following up patients if risk factors for disease had been identified at the health check and how further investigations were scheduled.

Patients who had a long term condition were invited for a health and medication review. Systems were in place to refer or signpost patients to other sources of support, for example smoking cessation or weight management clinics. With their consent, patients who had mental health issues were referred to the local Improving Access to Psychological Therapies (IAPT) team, who could offer counselling, support and advice as appropriate.

They offered a full range of immunisations for children, flu vaccinations and travel vaccinations in line with current national guidance. Data showed childhood immunisation rates for the practice were above average for Sheffield Clinical Commissioning Group (CCG). They had achieved a 99% uptake rate for all childhood immunisations offered between the ages of 0 to 5 years.

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

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information form the National Patient Survey (January 2015), where from 246 questionnaires, 104 (42%) responses were received. The survey showed 87% of respondents said the GP was good at giving them enough time and 85% said the GP was good at listening to them. These were average for the CCG (86% and 87% respectively).

Patients completed CQC comment cards to tell us what they thought about the practice. We received 48 completed cards which were all positive about the service they experienced.

We also spoke with 12 patients on the day of our inspection, the majority of whom told us they were satisfied with the care they received and staff treated them with dignity and respect. In some of the comments patients had complimented individual clinical and non-clinical staff by name.

We observed reception staff were courteous and spoke respectfully to patients. They listened to patients and responded appropriately. The staff we spoke with told us they were always careful what questions they asked patients at the reception desk and were aware of the need to maintain confidentiality. We were told there was a room available if patients wished to have a private conversation with a member of the reception staff.

Clinical staff explained how they protected a patient's dignity during consultation and when undertaking any examinations, for example when taking cervical smears. We noted curtains were provided in consulting and treatment rooms and the doors were closed during consultations. Conversations taking place in these rooms could not be overheard.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour, or where a patient's privacy and dignity was not being respected, they would raise these concerns with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice good in these areas. For example, data showed 74% of respondents said the GP involved them in decisions about their care, which was average for the local CCG.

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

Clinical staff told us written care plans were undertaken in conjunction with patients who had a long term condition, these included self-management plans. For example, newly diagnosed diabetic patients were given information of how to manage their condition and where to access help and support when required. The care plans were adapted to meet the needs of each individual. The information was designed to help patients manage their own health care and well-being to maximise their independence and also help reduce the need for unnecessary hospital admission.

Patient/carer support to cope emotionally with care and treatment

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

The GPs we spoke with appeared to have a good working knowledge of their patients and had a good understanding of their holistic care needs. Patients we spoke with also commented on how they felt cared for and supported.

The practice manager gave us an example of an elderly couple who would regularly attend the practice. It had been noted by reception staff they had not been seen for a while. Staff had then alerted the GP who made a home visit to the couple's address and had found the patients' health

Good

Are services caring?

and social conditions had deteriorated considerably. As a result referrals were made to other health and social care agencies to provide additional care and support as required.

The practice informed us if a patient experienced a bereavement a GP would contact them to offer support and signpost to other services as appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice told us they engaged regularly with Sheffield Clinical Commissioning Group (CCG) and other agencies to discuss the needs of patients and service improvements.

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

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

Tackling inequity and promoting equality

The practice had recognised the needs of the different population groups in the planning of its services. The practice had systems in place which alerted staff to patients with specific needs or who may be at risk. For example, patients who may be living in vulnerable circumstances.

There were male and female GPs in the practice, giving patients a choice as to whom they may wish to see.

The majority of the practice population were English speaking but access to interpreting services was available if required. The practice website had a function which enabled information to be translated in a variety of languages. Additional services within the practice were available for patients who may have a hearing or visual impairment. A patient we spoke with, who had a severe hearing impairment, told us the practice always provided an interpreter to support good communication between them and the clinical staff.

There was disabled access to the building via a ramp, although the doors were not electronically operated.

Reception staff could see if there was anyone having difficulty getting into the building and offer assistance as required. All consulting and treatment rooms were on the ground floor.

Access to the service

Comprehensive information regarding the practice opening times and how to make appointments was available in the reception area, the practice leaflet and on the website. Patients could book appointments by telephone, online or in person at the reception. Some appointments were pre-bookable and some were allocated to be booked on the same day. At the time of our inspection the next available pre-bookable appointment was within 48 hours. Home visits were offered for patients who found it difficult to access the surgery. We were informed same day appointments were available for all children under the age of 16 years.

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

We reviewed the most recent data available from the national GP patient survey for the practice regarding patient satisfaction and access. This indicated patients were generally satisfied with the appointments system at the practice. For example:

- 90% found it easy to get through to the practice by telephone (CCG average 71%)
- 89% usually get to see or speak with their preferred GP (CCG average 58%)
- 95% say the last appointment they got was convenient (CCG average 91%)
- 71% usually wait 15 minutes or less after their appointment to be seen (CCG average 70%)

The majority of patients we spoke with on the day or our inspection told us they found it easy to make an appointment and were usually offered an appointment to suit their needs.

The practice manager informed us they did weekly monitoring of availability of appointments. In busy periods, for example winter season, the practice would then offer a triage or telephone ring back service.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice. They told us how they handled complaints. This included acknowledging the complaint within two working days of receipt. Patients were signposted, as necessary, to the Parliamentary and Health Service Ombudsman and also an independent complaints advocacy service (ICAS).

At the time of our inspection we could not look at any complaints for the past 12 months. The practice manager informed us they had not received any complaints and there had been a decrease in complaints from the previous 12 months (when they had received nine).

We saw there was information in the practice leaflet and website advising patients about the complaints system. However, we did not see any information available in the patient waiting area. The practice manager advised us they would ensure information would be made visible for patients who attend the practice. Some patients we spoke with were aware of the process to follow if they wished to make a complaint, although they had not needed to do so.

The practice manager also showed us a folder they kept which contained numerous letters and cards of compliments from patients. These were shared with all the practice staff. Prior to the inspection we also saw compliments had been received through CQC's Share your Experience.

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

Staff we spoke with told us the vision and values of the practice were to maintain provision of a good service which provided excellent care and promote positive outcomes for its patients. They told us they delivered a professional service in a friendly, caring and respectful way. This was evidenced through patient comments.

Governance arrangements

The practice had management systems in place. They had appropriate policies to govern activity, which incorporated national guidance and legislation. These were easily accessible for staff.

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

The practice had arrangements to manage risk. We were informed the practice manager and GP met regularly to discuss any potential areas of risk both to patients and the practice. They also did regular walk rounds of the practice to identify any risks or hazards which could impact on patient and staff safety.

Leadership, openness and transparency

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

Staff told us there was an open culture within the practice and all members of the management team were approachable, supportive and appreciative of their work. There was a proactive approach to incident reporting and a 'no blame' culture was evident at the practice.

Staff spoke positively about the practice and how they worked collaboratively as a team and with other health professionals in meeting the needs of patients.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. The practice also participated in the NHS friend and family test and information was available both in the practice and on their website.

The practice did not have an active patient participation group (PPG), despite making numerous attempts to encourage patients to form a group. However, staff told us they felt patients would identify any areas of concern, which would be reported to the practice manager to action. At the time of our inspection some of the patients we spoke with expressed concern regarding the practice telephone number as being premium rate. This was identified to the practice manager who informed us the practice was in the process of changing the telephone number to a non-premium rate to take into account the comments made by patients.

Staff told us they were encouraged and would not hesitate to raise any concerns or provide feedback. They felt involved and engaged in the practice to improve outcomes for both patients and staff.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. Although staff had appraisals, these were not done on a formal basis using a structured framework which included a personal development plan.

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