

Moorcroft Surgery

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?	Requires improvement		
Are services effective?	Good		
Are services caring?	Good		
Are services responsive to people's needs?	Good		
Are services well-led?	Good		

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Moorcroft Surgery on 8 July 2015. Overall the practice is rated as good.

Specifically we rated the practice as good in providing safe, effective, caring, responsive and well-led services. It was also good for providing services for all of the population groups.

Our key findings were as follows:

- Patients said they found it easy to make an appointment with a preferred GP, there was continuity of care and urgent appointments were available the same day.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

- Patients told us they were treated with kindness, warmth, compassion and respect by staff. Staff ensured there was sufficient time to explain the care and treatment they were providing in a way patients understood.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- Risks to patients were assessed and managed.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded and addressed

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

Importantly, the provider must:

Summary of findings

- Ensure infection prevention and control, recruitment and selection and the incident reporting policies and procedures include and reflect current practice.
- Ensure a record is kept of blank prescriptions held within the practice.
- Ensure all staff have an up to date DBS check.
- Ensure all equipment, such as syringes, sterets and needles are within there expiry date.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services. There were enough staff to keep patients safe. 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. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and staff could provide examples of where improvements had been made to improve safety. There were effective processes in place for safe medicines management.

However, there were areas of practice where the registered provider needs to make improvements. The registered provider should ensure infection prevention and control, recruitment and selection and the incident reporting policies and procedures include and reflect current practice. A record is kept of blank prescriptions held within the practice and all staff have an up to date Disclosure and Barring Service (DBS) check.

Requires improvement



Are services effective?

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 and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. There was evidence of annual appraisals and staff had received training appropriate to their roles. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients spoke highly of the care they received from the practice. They commented they were treated with compassion, kindness, respect and dignity while they received treatment. Information to help patients understand the services was available and easy to understand. Staff described to us how they ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood. Patients commented they felt fully involved in their treatment, it was explained to them and they felt they were listened to and not rushed.

Good



Summary of findings

Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and North Leeds 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 adequate facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available both in the practice and on the website. Learning from complaints was shared with staff.

Good



Are services well-led?

The practice is rated as good for being well-led. It had a vision and strategy and staff were clear about their roles and responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures in place. 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. There was an active patient participation group (PPG) who told us they felt engaged with the practice.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. Nationally reported data showed outcomes for patients were good for conditions commonly found in older people. All patients over 75 years of age had a named GP and were offered an annual health check. The practice was responsive to the needs of older people, offering home visits and longer appointments. The practice worked closely with other health care professionals to ensure housebound patients received the care they needed. The practice provided services to 78 patients in nursing homes. The practice had good interactions with the nursing homes and they were involved in a care home project to improve prescribing. Patients in nursing homes and all home visits by the GP were discussed daily by the GPs to share information.

Good



People with long term conditions

The practice is rated as good for the care of people with long term conditions. The practice had a nurse-led approach to long term conditions, supported by the nursing staff. All of the GPs had specialist roles including diabetes. There were structured annual reviews in place to check the health and medications needs of patients were being met. Patients who were due an annual asthma review had access to an online review form. The practice used a chronic pain pathway as part of a pilot locality scheme to assess patients with chronic pain management and develop a care plan. Staff worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

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. The practice provided sexual health support and contraception, maternity services and childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice told us all young children were prioritised, urgent appointments were managed through telephone triage and the under-threes were seen on the same day as requested. Patients we spoke with confirmed this and said it was an excellent service for children.

Good



Summary of findings

Working age people (including those recently retired and students)

Good



The practice is rated as good for the care of working age people (including those recently retired and students). The practice had extended hours on Mondays to 8.00 pm. 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 care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It carried out annual health checks and offered longer appointments for people with a learning disability. Patient status alerts were used within the clinical system to make staff aware when they are dealing with a vulnerable patient. The practice used Clinical meetings and daily doctors meetings in the case management of vulnerable people.

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

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, for example a receptionist had trained in sign language.

People experiencing poor mental health (including people with dementia)

Good



The practice is rated as good for the care of people experiencing poor mental health, including people with dementia. The practice offered annual health reviews, longer appointments and home visits as needed for all patients who had poor mental health or dementia. The GPs provided home visits to three lived in dementia units and one learning disability high dependency unit. The practice had undertaken an anti-psychotic prescribing audit for patients living with dementia. Patients suffering with depression could complete a questionnaire which was used by the GP to monitor the severity of depression and response to treatment. It was also used to make a tentative diagnosis of depression.

Summary of findings

What people who use the service say

We spoke with nine patients and a member of the patient participation group (PPG) on the day of our visit. These patients covered a range of ages and population groups. The patients we spoke with were very positive about the care and treatment they received at the practice. They told us they received excellent care and an exemplary service both in clinical care and customer service.

Patients commented they were involved and supported emotionally in all aspects of their care. They told us staff were friendly, enthusiastic, understanding, sympathetic, helpful and caring. They said they were always treated with dignity and respect. Common themes from patients was one that they felt the staff went above and beyond their duty of care and were willing to go that extra mile for them.

We received 23 CQC comment cards which patients had used to record their experience of the service they received from the practice. All the comments on the cards

were very positive and complimentary; many citing the service they received as being 'excellent and brilliant'. There were several very complimentary comments which specifically identified individual practice staff.

The practice had an active and engaged PPG which consisted of 12 members. The purpose of the group was to provide an avenue for patients' input into the way facilities and services were planned and delivered, to add humanity to, and influence those services. We saw the practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the PPG. There was a clear partnership between the practice and patients to create and improve two-way communication and feedback.

We looked at the National Patient Survey, which had sent out 302 surveys and received 123 responses (41% completion rate). Ninety two percent of respondents said they would recommend the surgery to someone new to the area.

Areas for improvement

Action the service **MUST** take to improve

- Ensure infection prevention and control, recruitment and selection and the incident reporting policies and procedures include and reflect current practice.
- Ensure a record is kept of blank prescriptions held within the practice.

- Ensure all staff have an up to date Disclosure and Barring Service (DBS) check.
- Ensure all equipment, such as syringes, sterets and needles are within there expiry date.

Moorcroft Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Moorcroft Surgery

Moorcroft Surgery is part of North Leeds Clinical Commissioning Group (CCG) and is located in one of the lesser socially deprived areas of Leeds. The practice operates from a two storey property, with all patient services being provided on the ground floor. The practice will be relocating to purpose built premises in 2016.

The practice provides General Medical Services (GMS) for a population of 6014 patients under a contract with NHS England. They are registered to provide the following regulated activities: treatment of disease, disorder or injury; family planning; surgical procedures, maternity and midwifery services; diagnostic and screening procedures.

The practice has two male GPs (one who is newly appointed and on a probationary period until August 2015), three female GPs and one salaried female GP. In addition, there is one female nurse practitioner, two female practice nurses and a female healthcare assistant. The clinical team are supported by a practice manager, a finance manager and a team of experienced administration and reception staff.

The practice opening times are Tuesday to Friday 8.30am to 6pm. Extended evening appointments are available on

Monday's 8.30 to 8pm. Once a month (except August and December) the practice is closed at 12.00 for training. Patients can access the appointment system in person at reception, by telephone or online via the practice website. 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. The practice also signposts patients on their website to the local pharmacist who can advise patients whether their symptoms can be treated 'over the counter', or whether they need to see a GP.

The practice provides chronic disease management clinics, such as asthma, chronic obstructive pulmonary disease, coronary heart disease, diabetes, hypertension and stroke. In addition they provide ante natal clinics, cervical smears, childhood health surveillance, childhood immunisations, contraception services, including coil fitting, minor surgery, smoking cessation and travel immunisations.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to CQC at the time.

Detailed findings

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 and North Leeds Clinical Commissioning Group (CCG) to share what they knew.

We carried out an announced inspection at Moorcroft Surgery on the 8 July 2015. During our visit we spoke with a range of staff including four GPs, one nurse, one healthcare assistant, two reception staff and the practice manager. We also spoke with nine patients who used the service and a representative from the Patient Participation Group (PPG).

We observed positive communication and interactions between staff and patients; both face to face and on the telephone within the reception area. We reviewed 23 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)

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. However, incidents were not being reported in line with the practice's incident reporting policy, as staff were not completing the online incident form.

We reviewed safety records, incident reports and saw two electronic systems were being used. We found there was a lack of evidence of the outcomes, learning and follow up of incidents. Staff we spoke with told us incidents were discussed at practice meetings. There were no formal minutes available to confirm this. The practice manager recognised the incident reporting system was as an area for improvement. They told us improvements would be implemented. For example, formal minutes would be taken of meetings and one electronic system would be used. In addition, all staff would have access to the system to enable them to input incidents on to the system in line with their policy. GPs told us they discussed significant events at the weekly doctors' meeting. However, the meetings were ad-hoc and the outcomes and patterns were not recorded in the minutes. The GPs provided us with examples of these events and actions taken. The practice manager said a meeting schedule would be put in place and the minutes would be detailed.

Learning and improvement from safety incidents

There were systems in place for how the practice managed safety alerts, significant events, incidents and accidents. Staff we spoke with provided us with examples of significant events and actions taken. They told us significant event analysis was discussed at clinical meetings and practice meetings to improve safety. Staff we spoke with confirmed there was an open and transparent culture. They knew how to raise issues for discussion and were encouraged to do so. We viewed the clinical meeting minutes and saw significant events were discussed, however there was a lack of evidence to reflect the outcomes and learning from significant events.

The practice manager showed us the two electronic reporting systems the practice used to record, manage all

clinical and non-clinical incidents. We looked at 26 records of reported incidents on one electronic system and 27 additional incidents recorded on a second electronic system. We found there was a lack of documented evidence of the outcomes, learning and monitoring of themes and trends of reported incidents. From discussions with the practice manager and the GPs we found they had identified areas for improvement following an incident. For example, the prescription process could be more robust. The practice manager told us an improvement plan was scheduled. The practice manager was aware and understood the gaps within the incident reporting system and gave assurances this would be addressed as a priority.

National patient safety alerts were disseminated by the practice manager to all staff and appropriate actions taken.

Reliable safety systems and processes including safeguarding

The practice had child protection and vulnerable adult policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams. One of the GPs was the safeguarding lead professional in the practice and was scheduled to undertake level 3 training in safeguarding. From discussions with staff they were all unclear who the safeguarding lead was. Staff told us they were confident about raising any concerns with the managers.

All staff had undertaken safeguarding training in the last 12 months. The practice manager discussed how the practice worked collaboratively with the appropriate authorities.

The practice had systems to manage and review risks to vulnerable children, young people and adults. Staff we spoke with were aware of their responsibilities, knew how to share information, record safeguarding concerns and how to contact the relevant agencies in both working hours and out of normal hours.

There was a system in place to highlight vulnerable patients on the practice's electronic record. The practice discussed any safeguarding concerns at clinical meetings.

There was a chaperone procedure which was visible on the waiting room notice board and in consulting rooms. A chaperone is a person who acts as a safeguard and witness

Are services safe?

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 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 told us staff who acted in the role of a chaperone would receive appropriate training.

Three nurses and six administrative staff, one whom acted as a chaperone had not received a Disclosure and Barring Service (DBS) check. There was no risk assessment in place. We saw the practice manager obtaining information from staff to complete the DBS checks during our visit and they gave assurances these would be completed as priority. However, the provider should ensure all staff have an up to date DBS check prior to employment.

Medicines management

We checked medicines stored in the treatment rooms and found they were stored securely and only accessible to authorised staff. We checked the refrigerators where vaccines were stored. Staff told us the procedure was to check the temperatures on a daily basis and record it. We found the records maintained were ad-hoc and not recorded daily. The practice manager said they would ensure an allocated nurse would be responsible for this. We looked at a selection of vaccines and found they were within their expiry date. We found a few syringes, sterets and needles had expired, we brought this to the attention of a staff member and they replaced them immediately.

We saw a positive culture in the practice for recording and learning from prescribing incidents and errors. The practice did a prescribing review every month, this identified patients who had missed their review and needed to be recalled and the GP invited them in for an appointment. This helped make sure appropriate actions were taken to minimise the chance of errors occurring again.

There was a repeat prescribing protocol in place. Requests for repeat prescriptions were taken in person at the reception desk, by post or online via the practice website. We were informed about checks that were made to ensure the correct patient was given the correct prescription. The prescribing clerk checks the medicine and dose and then the GP signs it. All prescriptions were reviewed and signed by a GP before they were issued to the patient.

The practice kept a record of blank prescription forms going out, but there was no record of how many were stored.

Cleanliness and infection control

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

An infection prevention and control (IPC) policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. We found the policy did not include what to do in the event of a body fluid spillage. Staff told us how they would respond to blood and body fluid spillages in accordance with current guidance. The practice manager told us the policy would be amended to reflect this. The practice had access to spillage kits and personal protective equipment (PPE), including disposable gloves and aprons, 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. There was a nominated lead for IPC who completed an IPC audit in June 2014.

There was a policy in place for the management, testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings). We saw records confirmed the practice carried out checks in line with this policy. The last assessment had been completed in July 2015.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw there was a schedule 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 in place. This did not include obtaining DBS checks and references to ensure

Are services safe?

staff were of good character. We viewed four staff files and saw they had obtained proof of identification, qualifications and registration with the appropriate professional body. We found not all appropriate recruitment checks had been undertaken prior to their employment. For example, there were no DBS checks for nine staff and minimal staff references. The most recent recruited member of staff in 2014 did not have a DBS check. The majority of the staff had worked at the practice for many years and had not had a recent DBS check. The practice manager informed us after the visit they had registered staff for on-line DBS checks.

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

Monitoring safety and responding to risk

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

environment and dealing with emergencies, for example health and safety and fire risk assessments. Each risk was assessed, rated and mitigating actions recorded to reduce and manage risk. The practice manager told us risks identified were discussed at practice meetings. There were no formal minutes to confirm this.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed the majority of staff had received training in basic life support or it had been scheduled. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff told us they knew the location of this equipment and how to use it. We saw records which confirmed it was checked on a monthly basis.

A business continuity plan was in place to deal with a range of emergencies which may impact on the daily operation of the practice. Identified risks included power failure, adverse weather and access to the building. The document contained relevant contact details for staff to refer. Staff talked confidently of what to do in the event of incident, such as a power failure.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with best practice guidance. They accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told clinicians normally held fortnightly clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. These meetings have become less frequent (monthly) in the last four months due to long term sickness of the lead nurse. The GPs meet daily to discuss clinical cases and to agree home visits. We found from our discussions with the GPs and nursing staff they completed thorough assessments of patients' needs in line with NICE guidance and these were reviewed when appropriate. For example, the practice were amending the templates used to reflect the new guidance for coronary heart disease.

We were informed GPs had a lead in specialist clinical areas such as dermatology, rheumatology, sexual health, palliative care, diabetes and cardiovascular disease. This allowed the practice to focus on specific conditions. Patients we spoke with said having a GP with a specialism supported them with their long term condition.

There were systems in place to identify and monitor the health of vulnerable groups of patients, such as domestic violence. We were told patients who had learning disabilities were given longer appointments and annual reviews were undertaken.

The practice had registers for patients with long term conditions, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). The practice also had a register of patients requiring palliative care. Regular meetings to discuss these patients' care needs were held with other appropriate professionals, such as members of the community matron, district nurses and palliative care nurse teams.

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

Staff across the practice had key roles in how they monitored and improved outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits and other improvements to the service.

The most recent data available to us showed the practice had achieved 94% of the available QOF points. 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. Information collected for the quality and outcomes framework (QOF) and performance against national screening programmes was used to monitor outcomes for patients. The practice was at or above average for many of the QOF domains, particularly in asthma, chronic obstructive pulmonary disease, heart failure, hypothyroidism, palliative care and epilepsy.

Although the practice did not have a full cycle audit system in place, we found clinical audits were routinely being undertaken, were reflective and changes made as a result. We were shown examples of 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 coil fitting.

Effective staffing

The practice had a training matrix in place which showed what training staff had completed and when refresher training was due. We reviewed staff training records and saw there were gaps where some staff had not undertaken essential training courses, such as first aid, health and safety, infection control and information governance. All staff had completed training in fire safety and safeguarding level one. Where training was due we could see staff had been booked on to the appropriate course.

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

Are services effective?

(for example, treatment is effective)

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.

The nurses at the practice provided long term condition reviews, travel advice, immunisations, wound dressings, suture removal, blood pressure checks, ear syringing, contraceptive advice, cervical smears and treatment of minor injuries. They were also able to give advice on healthy diets, heart disease prevention and foreign travel. They had undertaken specialist training in COPD, dementia, cervical screening and vaccinations to perform these defined duties. The nurses were registered with the Nursing and Midwifery Council (NMC). To maintain registration they had to complete regular training and update their skills. We looked at staff folders, these contained relevant certificates to confirm nurses' professional development was up to date and they had received training necessary for their role.

All staff told us they felt very much supported in their role and confident they could raise any issues with the practice manager or the GPs. They had annual appraisals where any training needs were identified and confirmed the practice was proactive in supporting or providing relevant training.

Working with colleagues and other services

The practice worked with other service providers and held regular palliative care meetings to monitor patients and review patients' needs. We saw minutes identified other health professionals who attended these meetings, for example district nursing staff, community matron, practice nurse and palliative care nurses.

The practice had systems in place to manage information from other services, such as hospitals and out of hours services (OOHs). Staff were aware of their responsibilities when processing discharge letters and test results.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out of hours provider to enable patient data to be shared in a secure and timely manner.

Staff used an electronic patient record to coordinate, 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.

We saw evidence that, when appropriate, information was shared with other services and professionals to meet patients' needs. Shared access of specific information was available to the palliative care team

Consent to care and treatment

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

They also spoke with confidence about Gillick competency assessments of children and young people, which were used to check whether these patients had the maturity to make decisions about their treatment. Patients we spoke with confirmed the clinicians take time to explain care and treatment thoroughly.

Health promotion and prevention

The practice offered NHS Health Checks and annual reviews to all its patients aged 40 to 75 years, patients with a learning disability, chronic disease or mental health problem. They offered a full range of immunisations for children, flu vaccinations and travel vaccinations in line with current national guidance. 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 carers direct.

The practice participated in the 'Winter Scheme' through North Leeds CCG. Specific appointment slots were created for patients over the winter period in 2014 who were elderly or elderly with complex needs.

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.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the National Patient Survey where from a survey of 302 questionnaires, 123 (41%) responses were received. The survey showed 95% of respondents said the last GP they saw or spoke to was good at giving them enough time, 95% said the last GP they saw or spoke to was good at treating them with care and concern. In addition 97% of respondents said the last GP they saw or spoke to was good at listening to them.

We reviewed 23 CQC comment cards patients had completed prior to the inspection and spoke with nine patients and a member of the PPG on the day of inspection. Patients spoke highly of the staff at the practice. They told us they were treated with kindness, compassion, dignity and respect whilst they received care and treatment. Staff we spoke with recognised the importance of providing patients with privacy, compassion and empathy. We observed positive interactions in the reception area and saw staff treated patients with kindness, warmth and support. Staff had a good rapport and relationship with patients who were treated with courtesy and respect. Staff could also provide examples of how they supported patients to cope emotionally with their care and treatment in a timely and appropriate manner.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting and treatment rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted consultation/treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

Care planning and involvement in decisions about care and treatment

The patients we spoke with and who completed CQC patient comment cards were very complimentary about the care provided by the clinical staff. They told us the GPs listened to them, explained treatments to them and

involved them in decisions about their care. The patients scored the GPs highly in the national GP survey in this area. For example, 100% of patients said they had confidence and trust in the last GP they saw or spoke to, 95% said the GP was good at explaining tests and treatments and 94% said they were good at involving them in decisions about their care.

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 and were never rushed. Patients said their long term health conditions were monitored and they said they felt very well supported and looked after.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 95% of respondents said the last GP they saw or spoke to was good at treating them with care and concern and 97% said the last GP they saw or spoke to was good at listening to them.

Patients we spoke with on the day of our inspection and the CQC comment cards we received highlighted staff were caring and compassionate and provided support when needed. They told us they had a named GP, who were kind, sympathetic and met their emotional needs.

Notices in the patient waiting rooms and on the patient website informed patients how to access a number of support groups and organisations, such as Carers Direct.

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 by staff. The reception staff spoke passionately about providing good patient care and how they always supported and accommodated patients where possible. They told us they knew the patients well and had built up a good relationship with them.

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 North Leeds 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.

The majority of the practice population were English speaking but access to interpreting services was available if required. The practice had a website 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.

The practice was in a small, non purpose built building, however it was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties. There was access to enabled toilets and baby changing facilities. There was a waiting area with space for wheelchairs and prams. Patients told us the car park was not sufficient. The practice manager informed us the practice will be moving to a purpose built practice in 2016 which could accommodate their increasing patient list.

Access to the service

The practice opening times are Tuesday to Friday 8.30am to 6pm. Extended evening appointments are available on Monday's 8.30 to 8pm. The practice holds monthly training sessions, whereby the practice is closed at 12.00 on a Thursday (with the exception of August and December). Signs were displayed in the practice to inform patients. We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey. This indicated patients were generally satisfied with the appointments system at the practice. For example, 82% described their experience of making an appointment as good and 94% said the last appointment they got was convenient.

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. The practice also offered a triage system whereby they could speak with a GP for advice. 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 three years.

Information was available in the practice and on their website regarding out of hours care provision when the practice was closed. Patients told us they were rarely kept waiting for their appointment and said it was not an issue if there was a delay. Patients could access care and treatment in a timely way and the appointment system met their needs.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling compliments, complaints and concerns. Information for patients about how to complain was available on the website. We saw there was information in the practice leaflet, a complaints leaflet and information on the 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 attended the practice. Patients we spoke with told us they

Are services responsive to people's needs? (for example, to feedback?)

didn't have any complaints but knew how to make a complaint should they need to. They told us they were extremely happy with the care they received and it was an excellent service.

The practice had a complaints policy for staff which provided them with clear guidance about how to handle a complaint. The policy included contact details of external organisations patients could contact if they were not satisfied with the provider's response to a complaint. The practice manager was the designated responsible person who handled all complaints in the practice.

We looked at the complaints received in the last 12 months. We found the practice had taken action and implemented improvements as a result. We saw steps had been taken to resolve the issue to the patient's satisfaction and a suitable apology and an explanation had been provided. It was evident from these records that the practice was responsive, open and transparent in dealing with complaints.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Our discussions with staff indicated the vision and values were embedded within the culture of the practice and patient care was a priority. We found staff were passionate and enthusiastic about the services they provided. They told us they always try and do their best for patients to deliver a good service. They also spoke highly about the provider and the management of the business. They said working at the practice was equivalent to being part of a family.

Governance arrangements

The practice had good governance arrangements in place to ensure risks were identified, understood and managed appropriately. We saw risk assessments and the control measures in place to manage those risks, for example fire and health and safety. There were a range of policies and procedures in use at the practice. We noted some of the policies needed reviewing to reflect current practice. Staff told us they attended practice meetings where governance was discussed. We found there were no formal minutes available to evidence this. The practice manager agreed meetings would be minuted and actions recorded.

There was an effective management structure in place to ensure responsibilities of staff were clear. Staff we spoke with told us they felt supported and were clear about their roles and responsibilities.

Although the practice did not have a full cycle audit system in place, we found clinical audits were routinely being undertaken, were reflective and changes made as a result. We were shown examples of 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.

The practice used the Quality and Outcomes Framework (QOF) and the organisations comprehensive audit tools to measure its performance. The QOF data for this practice showed it was performing in line with national standards in most areas.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice. This was evident from discussions with staff and from records we reviewed. Staff told us the GPs and practice manager were approachable, accommodating, supportive and would find time for them.

Staff told us they could openly contribute and discuss how the practice could improve. They told us there was an open culture within the practice and they felt engaged and the practice management team listened and acted on their ideas and suggestions. For example, a prescription box was placed in the waiting area to reduce congestion and maintain patient confidentiality at the reception area.

Staff spoke positively about the practice and how they worked collaboratively as a team and with other health professionals in meetings the needs of patients. They told us they were happy and confident to raise any issues and felt their opinions were listened to and valued.

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 sought the views of patients through the Patient Participation Group (PPG) and the friends and family test.

It had an active PPG (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care), which included representatives from various population groups, for example older people, people with long term conditions, working age population and people experiencing poor mental health (including people with dementia). The PPG had carried out annual surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. As a result of the survey the practice had undertaken an appointment analysis which had resulted in setting up an appointment text reminder system. We spoke with one member of the PPG and they were very positive about the role they played and told us they felt engaged and listened to by the practice.

The practice had gathered feedback from staff through meetings, surveys, appraisals and discussions. Staff told us they felt involved and engaged in the practice to improve outcomes for both patients and staff and they felt valued as

Are services well-led?

Good 

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

a member of the practice. 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. Staff survey results were positive, it showed staff had been involved in the re-location to new premises.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. They told us annual appraisals took place, which included a personal development plan. This was evidenced in the staff files we looked at.

The practice used complaints, audits and significant events and other incidents and shared the information at staff meetings to ensure the practice improved outcomes for patients. The practice meetings were not always recorded to corroborate this. However, discussions with staff confirmed this information was being shared within the team.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Family planning services	Good Governance Regulation 17 (2) (d)
Maternity and midwifery services	(I) persons employed in the carrying on of the regulated activity, and
Surgical procedures	(ii) the management of the regulated activity
Treatment of disease, disorder or injury	

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed
Family planning services	Fit and proper persons employed Regulation 19 (1)
Maternity and midwifery services	(a) be of good character
Surgical procedures	
Treatment of disease, disorder or injury	