The Practice Harehills Corner

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection visit on 21 October 2014 and the overall rating for the practice was good. The inspection team found after analysing all of the evidence that the practice was safe, effective, caring, responsive and well led.

Our key findings were as follows:

- The practice provided good, safe, responsive and effective care for all population groups in the area it serves.
- All areas of the surgery were visibly clean and where issues had been identified relating to infection control, action was being taken.
- Where incidents had been identified relating to safety, staff had been made aware of the outcome and action taken where appropriate, to keep patients and staff safe.
- Patients received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to ensure they were up to date with best practice.
- The service was responsive and ensured patients received accessible, individual care, whilst respecting their needs and wishes.
- The service was well led and there were positive working relationships between staff and other healthcare professionals involved in the delivery of service.

We saw several areas of outstanding practice these included:

- A care co-ordinator was in post at the practice; the role was to support the most vulnerable patients and their carers to reduce hospital admissions. This was a new innovation.
- A health trainer was in place to support weight management, alcohol reduction and smoking cessation for patients with identified need.

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, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement and to minimise future risks. We saw risks to patients were assessed and well managed. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep people 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 National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current guidance. This included assessing capacity and promoting good health. Patients were referred to secondary (hospital) care in a timely manner. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice had systems in place to monitor and support staff. These included appraisals and personal development plans for all staff. The practice staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Information from different sources showed patients rated this practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw staff treated patients with kindness and 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 Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients mainly said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available on the day.

Summary of findings

The practice had appropriate facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. Evidence showed that the practice responded quickly to issues raised, learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their 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 to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) met three times a year. Staff had received inductions, regular performance reviews and attended staff meetings and learning events.

Summary of findings

What people who use the service say

We received 31 completed CQC comment cards and spoke with three patients on the day of our inspection. We were unable to speak with a member of the Patient Participation Group (PPG) on the day; however we spoke with a member at a later date.

The patients spoke highly of the care provided by staff; their nice attitudes and overall customer satisfaction were mentioned. All patients said they were involved and felt supported in the planning and decision making of their care. They felt the clinical staff were knowledgeable about their treatment needs and they were given a caring, compassionate and efficient service. They told us the reception staff were welcoming , helpful and efficient. Overall they felt the communication skills of the staff were really good.

Patients reported that staff treated them with dignity and respect and they were given support and information to cope emotionally with any care or treatment. Patients said the service met their needs and was very good. They felt that their views were valued by the practice and they were listened to. Out of the 31 CQC comment cards, only two patients commented on the difficulties in arranging appointments.

We looked at the patient comments and feedback on the NHS Choices website. One positive comment made from a patient said they were happy with the practice; they could always get an appointment and being able to book these in advance was particularly beneficial.

Outstanding practice

- A care co-ordinator was in post at the practice; the role was to support the most vulnerable patients and their carers to reduce hospital admissions. This was a new innovation.
- A health trainer was in place to support weight management, alcohol reduction and smoking cessation for patients with identified needs.

The Practice Harehills Corner

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 GP, a practice manager and we had a Department of Health observer in attendance too.

Background to The Practice Harehills Corner

The Practice Harehills Corner is located on Roundhay Road in Leeds and provides primary care services to 3,454 patients. Eighty percent of the practice population are under 40 years of age. The surgery is part of the Practice PLC based in London which holds contracts for over 50 GP surgeries and GP led Health Centres across the UK. There is disabled access at the front of the building and on street parking is available.

The practice is registered with the CQC to provide the following regulated activities: diagnostic and screening, family planning, maternity and midwifery and treatment of disease or injury.

The Practice has one full time male salaried GP and two part time GPs working Monday, Wednesday and Friday full days. Alongside this GP is a part time female practice nurse and a part time female health care assistant. In addition there is a care-co-ordinator based at the practice for two days each week. This new initiative is to help reduce unplanned admissions to secondary (hospital) care. There is an experienced practice manager who is supported by a team from head office and the administration and reception staff within the practice. Staff are supported through an appraisal system and training.

The practice has a Primary Medical Services (PMS) contract. PMS is a locally agreed alternative to General Medical Service (GMS) for providers of general practice.

The practice is open Monday to Friday 8:00 am to 6:30pm. Their extended hours are until 7.30pm on a Monday and from 07.30am on Friday mornings. A range of appointments are available, including telephone consultation with a GP and urgent appointments on the same day. People are able to book these in person, over the phone or on-line. The practice also offers home visits for patients who are unable to attend the practice. When the practice is closed the Out of Hours cover for patients is provided by Local Care Direct.

A wide range of practice nurse led clinics are available for patients at the practice. These include vaccinations and immunisations, cervical smears, family planning, removal of sutures and clips, and chronic disease management such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and heart disease. The midwife also provides a clinic for pregnant women.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme covering Clinical Commissioning Groups throughout the country. The Practice Harehills Corner is part of the Leeds South and East CCG and was randomly selected from the practices in the Leeds South and East clinical Commissioning Group (CCG) area.

Detailed findings

How we carried out this inspection

Before visiting The Practice Harehills Corner, we reviewed information we hold about the practice and asked other organisations to share what they knew. We asked the practice to provide us with a range of policies and procedures and other relevant information before the inspection to enable us to have an overview of the practice. We carried out an announced visit on 21 October 2014. During our inspection we spoke with staff including GPs, practice nurses, the care co-ordinator, the practice manager, administration and reception staff. We spoke with three patients who used the service and later we spoke with a member of the Practice Participation Group (PPG). A PPG is a group of volunteer patients who meet with the practice manager and GPs to discuss the services provided by the practice. We observed how patients were being spoken with and talked with carers and family members. We reviewed comment cards where patients shared their views and experiences of the service.

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 demonstrated that it had a safe track record. Information from the Clinical Commissioning Group (CCG) and Healthwatch indicated that the practice had a good track record for maintaining patient safety. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that the practice had not received any safeguarding or whistleblowing concerns. Safety was monitored using information from a range of sources including the QOF, patient survey results, patient feedback forms, the PPG, clinical audit, appraisals, professional development planning, education and training. The practice also used an electronic system to monitor safety.

The practice had developed clear lines of accountability for all aspects of patient care and treatment. The GPs and nurses had lead roles such as medicine lead and infection control lead. Each clinical lead had systems for monitoring their areas of responsibility, such as routine checks to ensure staff were using the latest guidance and protocols in their treatment of patients.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events and there were up to date policies in place. We also saw evidence of internal investigations which were carried out when significant events occurred. We saw the protocol had changed between the local pharmacy and the practice. Staff we spoke with confirmed that the service had improved following this learning. In addition the clinical staff told us what action they and the non-clinical staff would take as a consequence of learning from incidents to improve their practice. We reviewed the minutes of clinical meetings and saw incidents were discussed in detail with actions and dates noted for re-audit.

Reliable safety systems and processes including safeguarding

There were policies and protocols for safeguarding vulnerable adults and children. Concerns regarding the safeguarding of patients were passed on to the relevant authorities by staff as quickly as possible.

Staff had received training relevant to their role and this included safeguarding vulnerable adults and children training. The lead GP informed us they had participated in local safeguarding meetings for their patients, when required. They told us they had level three safeguarding training and this included adults and children. They were aware of the national and local guidelines and were able to give examples where they had identified patients at risk and the action they had taken in line with current protocols. We saw that alerts were placed on patients' electronic records to inform staff of any safeguarding issues for individual patients who attended for consultation.

We saw an up to date chaperone policy and protocol. We saw the cervical smear template which asks the questions about consent and chaperone.

Medicines management

The lead GP prescriber for medicines had meetings at the practice with a representative from the Leeds (South and East) CCG. There were appropriately stocked medicine and equipment bags ready for doctors to take on home visits. One doctor's bag was checked and we found the contents were safety sealed and in date.

We checked the refrigerators where vaccines were stored. We saw there were systems in place to check the refrigerators were working at the correct temperatures and records were maintained to evidence this. We looked at a selection of the vaccines stored and found they were within their expiry date. The practice nurse was responsible for carrying out both temperature and stock control checks. The fridges were adequately maintained by the manufacturer and the staff were aware of the actions to take if the fridges were ever found to be out of the correct temperature range. There were standard operating procedures (SOP) in place for the use of certain medicines and equipment. The nurse used patient group directives (PGD). PGDs are specific written instructions which allow some registered health professionals to supply and/or administer a specified medicine to a predefined group of patients, without them having to see a doctor for treatment. For example, flu vaccines and holiday immunisations. These ensured all clinical staff followed the same procedures safely. The SOPs and PGDs we saw were in date and clearly marked which helped staff identify and refer to the correct document. Patients can be confident that they received their medicines safely and in line with guidance produced by the National Institute for Health and Care Excellence (NICE).

Good

Are services safe?

We saw on the Harehills Corner web site, their practice leaflet and from discussions with the practice manager that patients could request repeat prescriptions. They could do this either by completing a repeat slip and returning by fax or in person and prescriptions could be collected from the pharmacy. They said this would be processed within 48 hours. The practice used an electronic system 'Connect' to support their prescribing decisions. This system gave the GPs access to up to date information and best practice guidance when prescribing medicines for patients. A record of prescriptions collected by the pharmacy was maintained electronically and also recorded in the patient's record.

There were procedures in place for GP reviews and the monitoring of patients on long term medicine therapy. Patients we spoke with confirmed that they received regular reviews of their medications.

When changes were requested to patients' prescriptions by other health professionals such as NHS consultants and/or following hospital discharge, the practice updated their records to reflect this.

The GP told us that they received medication alerts from the Clinical Commissioning Group (CCG), National Institute for Health and Care Excellence (NICE) and Medicines Products Regulatory Agency (MHRA). Any changes in guidance about medicines were communicated to clinical staff in practice meetings. We were told that where there had been changes to guidelines for some medicines, audits had been completed. Clinical audits in relation to antibiotic prescribing and the Local Enhanced Service for monitoring Amber drugs agreement had been completed and a review of outcomes and the effectiveness of any action taken had also been completed.

Cleanliness and infection control

The practice had an infection control policy and guidelines in place. This meant staff had guidance to refer to should they need assistance in the systems and processes to use in the management of infection prevention control (IPC). The policy provided staff with information regarding infection prevention, including hand hygiene, sharps injury, personal protective equipment (PPE) and single use medical devices. All staff had completed training in IPC. Audits of the IPC processes were completed annually and an action plan had been implemented to address any identified shortfalls.

Standards of cleanliness and hygiene were maintained at the practice. We observed most areas of the practice to be visibly clean and tidy. Cleaning schedules were available. Colour coded cleaning cloths and mops were used to avoid the risk of cross contamination/infection. In addition the practice undertook audits of cleaning compliance every month and we saw evidence of actions taken.

We saw the hand washing facilities, hand gel dispensers; paper towels and instructions about hand hygiene were available throughout the practice. We saw clinical bins were foot operated and clinical waste was segregated from ordinary waste. We were told the practice did not use any instruments which required decontamination between patients and that all instruments were single use. We observed the practice had stocks of instruments and that these were within their expiry date.

The sharps bins were appropriately assembled, they signed and dated in accordance with IPC guidance. Personal protective equipment (PPE) such as disposable gloves and aprons were available in the examination areas.

The practice had legionella assessments in place. We were informed the premises were owned by a private landlord and the practice was working with them to take the appropriate remedial action which was identified and required to comply with Health and Safety Building Regulations and British Standards.

Equipment

The maintenance and use of equipment kept patients safe. Emergency equipment included a defibrillator and oxygen which was readily available for use in a medical emergency. We saw they had been checked regularly to ensure they were in working condition.

We saw that equipment had up to date portable appliance tests (PAT) completed and systems were in place for routine servicing and calibration of equipment where required.

Equipment was clean and functional. Items were labelled with the last service date.

Staffing and recruitment

Staffing levels and skill mix were planned and were constantly reviewed at the practice so patients received safe care and treatment at all times. Staff told us there were sufficient numbers of staff employed by the practice to provide cover for sickness and holidays.

Good

Are services safe?

The practice had an effective recruitment policy and procedures in place. Most staff had been employed for a number of years and there was a low turnover and sickness record. Staff recruitment was recorded on the electronic system. We looked at two staff files during the inspection, one of whom was recently employed. We found these files to be well maintained. Each file contained proof of identification, references and a clear record of training undertaken. We saw the practice had obtained Disclosure and Barring Service (DBS) checks for all new employees recruited since April 2013 and retrospective checks had been undertaken for all clinical staff.

The practice had a Service Level Agreement (SLA) in place with an agency for recruiting locums. They told us they usually used the same locums for consistency. We saw appropriate checks had been undertaken which included a GMC reference number, medical indemnity, performance checklist and a DBS check.

Monitoring safety and responding to risk

The Practice Harehills Corner responded to and managed risks. The practice had developed clear lines of accountability for all aspects of care and treatment. The GPs and healthcare assistant were allocated lead roles in areas such as safeguarding and infection control.

A system was in place to respond to safety alerts from external sources which may have implications or risk for the practice. These included NHS England, Medicines and Healthcare Products Regulatory Agency (MHRA) and National Patient Safety Agency (NPSA). Staff were informed of the alerts via email and in meetings. The practice used a computerised system to store all documents including the alerts.

Comprehensive risk assessments were carried out for people who used services. We saw that there were numerous risk assessments in place such as fire, violence and aggression, Control of Substances Hazardous to Health (COSHH) and health and safety. These were reviewed annually.

Staff demonstrated they were able to identify and respond to changing risks to patients who used the services, for example in medical emergencies or with sharps injuries. They said they have a sharps injury procedure to follow should one occur. Staff could alert clinical staff by using a panic alarm and they had access to emergency equipment. Staff told us they had and could seek support from senior staff in these situations.

Arrangements to deal with emergencies and major incidents

Potential risks to the practice were anticipated and planned for in advance. There were effective business continuity plans in place to deal with emergencies that might interrupt the smooth running of the service such as power cuts, loss of telephone system and adverse weather. Staff were able to describe the procedure of what they would do in the event that the telephone system went down.

The practice had a health and safety emergency evacuation procedure in place. Staff talked confidently about what to do in the event of an emergency. We found all staff were trained in Cardio Pulmonary Resuscitation (CPR) which included Automated External Defibrillator (AED) and anaphylaxis to support patients who had an emergency care need. Emergency equipment was checked and available for staff to access in an emergency. This equipment was recognised as being of a very high standard.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patient's needs were assessed and care and treatment considered, in line with current legislation, standards and evidence-based guidance. We spoke with the GP who told us they used relevant and current evidence-based guidance such as the National Institute for Health and Care Excellence (NICE) guidelines and used the CCG best practice guidelines to develop service, care and treatment delivery.

Patients had their needs assessed and their care planned and considered in line with evidence-based guidance, standards and best practice this included when patients were referred to other services . The practice had employed a care co-ordinator whose role was to prevent hospital admission for the most vulnerable patients within the practice. They used the clinical assessment to inform the support and signposting to external organisations required. Although this was a fairly new post it was already making a difference for some
patients.

Management, monitoring and improving outcomes for people

Information about the outcomes of patients' care and treatment were routinely collected by the practice. The GP and practice manager told us this was done through audits, patient survey, patient participation group (PPG), NHS Choices website and the GP survey.

Staff were involved in activities to monitor and improve patients' outcomes. The practice nurse was the long term conditions lead (LTC) these included diabetes, asthma and chronic obstructive pulmonary disease (COPD). The health care assistant was the dementia lead and they both discussed activities to monitor and improve patient's outcomes with the GPs. The practice nurse told us and we saw on the computerised system, how the practice carried out monthly monitoring of patients taking 'high risk drugs' to ensure they received their recalls to the practice. Abnormal blood test recalls were also followed up monthly and action taken where appropriate in consultation with the lead GP.

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

Effective staffing

Staff had the skills, knowledge, qualifications and experience to deliver effective care and treatment. Staff received appropriate training to meet their learning needs and to cover the scope of their work. We were able to review staff training records and we saw that this covered a wide range of topics such as equality and diversity, health and safety and infection control. The practice ensured all staff could readily update both mandatory and non-mandatory training and this was provided through e-learning and face to face training. Newly employed staff were supported in the first few weeks of working in the practice. An induction programme included time to read the practice's policies and procedures. Staff managed their own training on the electronic system and they had protected learning time for training.

The learning needs of staff were identified and discussed in their appraisals. We viewed staff appraisals and saw evidence of this. Their appraisals were undertaken annually and these were retained on 'We looked at two staff appraisals and saw they were given the opportunity to comment on their progress and training needs for the future. Clinical staff told us they had dedicated supervisions and they received an appraisal with an appropriate clinical peer. The practice nurse was supported to maintain their record of Continuing Professional Development (CPD). The GP told us they were up to date with their CPD and revalidation.

Staff told us they felt they had opportunities to develop and were able to take study leave to attend courses. We spoke with reception staff who told us that they were encouraged and supported to develop in their roles and had undertaken additional training such as customer services and National Vocational (NVQ) qualifications. The practice manager told us how they had been supported to develop from a receptionist role to their current role.

There were arrangements in place for supporting and managing staff to deliver effective care and treatment.

Good

Are services effective?

(for example, treatment is effective)

Reception staff had monthly team meetings with the practice manager where they could openly raise any concerns or issues. They felt supported and enjoyed working within the team.

Working with colleagues and other services

We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. There were regular monthly meetings with the multi-disciplinary team within the locality. This included district nurses and health visitors. There were also regular informal discussions with these staff. This helped to share important information about patients including those who were most vulnerable and high risk.

The practice had systems in place for recording information from other health care providers. This included out of hours services and secondary care providers, such as hospitals. We spoke with practice staff about the formal arrangements for working with other health services, such as consultants and hospitals. They told us about how the practice referred patients for secondary (hospital) care. When a referral was identified, the practice always tried to book an appointment, using the, 'choose and book' system.

We saw the systems in place for managing blood results and recording information from other health care providers including discharge letters. The GP viewed all of the blood results and took action where needed. If any concerns identified these would be raised in the multi-disciplinary team meetings for action.

Information sharing

The practice staff worked closely with the local community nursing team which included the health visitor. Monthly meetings were held and a member of the palliative care team also attended. At these meetings, individual patients and the care they were receiving from each professional group was discussed and records updated.

There was a system in place to ensure the out of hours service and NHS 111 had access to up-to-date treatment plans of patients who were receiving specialist support or palliative care. This ensured care plans were followed, along with any advanced decisions patients had asked to be recorded in their care plan.

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). They confirmed their understanding of capacity assessments and how these were an integral part of clinical practice. 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. All staff we spoke with understood the principles of gaining consent including issues relating to capacity. We saw information relating to the five principles to be considered when seeking consent in each clinical room.

Clinical staff were able to confirm how to make 'best interest' decisions for people who lacked capacity and how to seek appropriate approval for treatments such as vaccinations from children's legal guardians. The practice had a consent policy available to assist all staff and this provided them with access to relevant consent form templates. Patients felt they could make an informed decision. They confirmed their consent was always sought and obtained before any examinations were conducted. They told us about the process for requesting and using a chaperone and felt confident that it was effective as it was available to them when needed.

Health promotion and prevention

Patients were supported to live healthier lives. New patients at the practice were given an appointment at registration, which was used as an opportunity to identify potential risks to the patient's health. Patients' individual needs were assessed and access to support and treatment was available as soon as possible. The practice had a health trainer to support with health promotion initiatives these included: weight management, smoking cessation and alcohol use. In addition a care co-ordinator was also in place to enable the most vulnerable patients to have access to support and care which in turn prevented unnecessary hospital admissions.

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

Good

Are services effective?

(for example, treatment is effective)

We saw the 'call and recall' system and how this worked within the surgery. This helped to ensure the timely and appropriate review of patients with LTCs and those who required periodic monitoring. Patients with more than one LTC were offered one recall appointment when all care and treatment could be reviewed. This included an appointment time which was longer to improve the patient experience.

We saw evidence of low levels of screening uptakes for bowel cancer. We were told the practice are actively writing to patients explaining the importance of the screening and encouraging them to participate. The practice is working with the CCG to improve the uptake of this screening.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in rooms which gave patients privacy and dignity. Patients at the practice told us they were treated with kindness, dignity, respect and compassion whilst they received care and treatment. They told us they were able to have confidential discussions with staff at reception and there was a room available to talk with staff in private should they choose to. They said that they had access to language line should they need it.

We saw the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. We saw there was a notice in reception about courtesy and respect when patients were waiting to book in. We were told this worked well by reception staff and the Patient Participation Group (PPG) member.

The practice had a chaperone procedure in place to support patients. There were signs prominently displayed in the reception and waiting room explaining that patients could ask for a chaperone during examinations if they wanted one. The healthcare assistant and members of the reception team had received chaperone training.

Care planning and involvement in decisions about care and treatment

The patients we spoke with said they had been involved in decisions about their care and treatment. They told us their treatment was fully explained to them and they understood the information. They felt the nurses and GPs would take time to re-word information if they did not understand.

We saw care plans for patients with specific health needs. They were adapted to meet the needs of each individual. This information helped patients to manage their own health, care and wellbeing to maximise their independence. Additionally those patients who needed support from carers could be assured that their needs would be met because of the careful care planning. There was evidence that these care plans were having an impact on reduced hospital admissions.

Staff recognised when patients who used the practice and those close to them needed additional support to help them understand or be involved in their care and treatment. The care co-ordinator played a role in helping them access the services they needed most. Staff had access to language line interpreters.

Patient/carer support to cope emotionally with care and treatment

We were told the regular palliative care meetings with clinical staff and community health professionals discussed patients, their carers and their need for support. They felt this worked well as patients and or their carers were emotionally and physically supported to cope with their treatments. We saw evidence of other signposting in the waiting room for patients who wished to self-help.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Care and treatment was planned and delivered to meet the needs of patients. Patients we spoke with told us the practice was providing a service that met their needs. The practice regularly sought the views of patients through the patient suggestion box, patient survey and the PPG which enabled patients to voice their concerns and needs.

Patients with immediate, or life-limiting needs, were discussed at the weekly clinical meeting to ensure all practitioners involved in their care delivery were up-to-date and knew of any changes to their care needs.

Staff said they had access, guidance and contact details of interpreter or translation services for patients. The staff also had access to leaflets in a variety of languages and could access these electronically as required.

Tackling inequity and promoting equality

Patients who needed extra support because of their complex needs were allocated double appointments. We saw specific tailored care plans to meet their needs for example patients with learning disabilities or those who suffered with dementia as well as LTCs. In addition a care co-ordinator was also in place to enable the most vulnerable patients to have access to support and care which in turn prevented unnecessary hospital admissions.

There was disabled access at the front of the practice and all treatment/clinical rooms were on the ground floor.

Access to the service

A range of appointments were available for patients, including telephone consultation with a GP where appropriate, urgent appointments on the same day and home visits. The practice supported patients to access appointments through booking on-line, telephoning the surgery or attending in person. The practice also offered home visits for patients who were unable to attend the practice. Out of hours services for the practice were directed from the practice to Leeds out of hours service. The majority of patients spoke very positively about the appointment system and told us it was meeting their needs.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice.

We reviewed a record of complaints for the practice and saw that there were good systems in place for reporting and receiving complaints. The outcomes of complaints, actions required and lessons learned were shared with the staff during their team meetings. The outcomes and any areas for improvement were also discussed at the PPG.

The complaints procedure was available to patients in the practice booklet. The patients we spoke with were happy with the care they received at the practice and they knew how to make a complaint should they need to.

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 GP and practice manager were able to sign post us to the practice's website for the vision and values. We found the Practice PLC had outlined their values on the website which incorporated areas such as; to make patients feel comfortable and cared for, patients are at the heart of what we do, encourage innovative thinking. The majority of staff we spoke with were aware of the strategy. They had a thorough understanding of their role in achieving a patient focussed service.

We saw the weekly newsletters from head office which was sent to all staff. This reported on clinical and staff issues. The practice had monthly staff meetings and ad-hoc bi-weekly meetings too. Staff told us this helped them keep up to date with new developments and concerns. It also gave them an opportunity to make suggestions and provide feedback to management. Staff told us they were committed to providing a good service for patients and they were enthusiastic about their contribution.

Governance arrangements

The practice had an effective governance framework to support the delivery of the strategy and good quality care to patients. There was an electronic system 'Connect' which recorded governance and enabled the practice and head office to monitor risks and improve performance. The practice manager and the governance lead at head office, took an active leadership role in overseeing the systems were consistently being used and were effective.

There was a clinical governance and quality assurance policy in place. This clearly outlined staff roles and responsibilities in supporting and upholding the aims of the policy and improving patient care. The practice manager, GP and staff we spoke with were very clear on their roles and responsibilities. We found that the team were allocated lead roles, for example the healthcare assistant was the lead for infection control and the GP was the lead for safeguarding.

Clinical and internal audit were used to monitor quality and systems used to identify where action should be taken. For example prescriptions were audited every 6 months. The results were discussed at the clinical meetings where areas for improvement were identified.

Leadership, openness and transparency

Leaders at the practice were visible and approachable, encouraged openness and transparency and promoted good quality care. Staff we spoke with confirmed that the managers were approachable and they had a good working relationship with them. They said they were able to discuss any concerns or issues with the management team. The practice manager said their door was always open to staff and they could have discussions in private or staff could speak with someone from head office should they choose. Staff told us they felt supported, respected and valued as a team member by the management team at the practice.

The culture of the practice was centred on the needs and experience of people who used the services. Staff told us that they always focussed on the patient's needs. The practice actively sought the views of the patients through the PPG, patient survey and the patient comments box. As a result of patient feedback the practice were in the process of recruiting a female GP for those patients who would prefer a choice.

The practice encouraged candour, openness and honesty, with regular meetings where challenge and debate could happen. All staff attended staff meetings and they told us that they were able to voice their opinions and felt listened to. The minutes of the meetings reviewed showed they regularly attended staff meetings and these provided them with the opportunity to discuss the service being delivered. Staff we spoke with told us their wellbeing was good. They said that as a team they supported each other and felt looked after by the management of the practice.

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

Patients' and staffs views and experiences were gathered and acted on to shape and improve the services and inform the culture of the practice. The practice had a PPG which contributed to decisions for improving services. The practice manager said they actively encouraged the PPG to be involved in decision making. However, the numbers were small and they were looking at different ways to encourage greater participation.

The practice had conducted a patient survey. The evidence from this showed patients were satisfied with the care and treatment provided by the practice and how they were

Are services well-led?

Good

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

treated. We received 31 completed Care Quality Commission (CQC) comment cards. The patients were complimentary about the care provided by the clinical staff and the overall friendliness and behaviour of staff.

Staff were very engaged with and committed to the practice and its patients. They spoke passionately about their roles and the patients and how they were supported to give patients the best care possible

Each member of staff we spoke with felt they had a voice and the practice was interested in creating a learning and supportive working environment.

Staff understood the value of raising concerns and they were able to raise these with the practice manager or through head office. They felt that they would be listened to and action taken where appropriate.

Management lead through learning and improvement

We saw that an induction programme was completed by new staff and that all staff had completed mandatory training. This included: fire safety awareness, information governance, safeguarding vulnerable adults and children and equality and diversity. The practice had clear expectations around refresher training and this was completed in line with national expectations. The practice held a record of all training undertaken and details of when refresher training would be required. Staff told us the training they received helped to improve outcomes for the patients. The staff we spoke with told us they felt supported to complete training and could request any additional training which would benefit their role.

The practice used information to continuously improve the quality of services. Staff were able to take time out to work together to resolve problems and information which was used to proactively to improve the quality of services.