

The Dove Valley Practice

Quality Report

Worsbrough Health Centre
Powell Street,
Worsbrough
Barnsley,
S70 5NZ

Tel: 01226 648150

Website: www.thedovevalleypractice.co.uk

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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 inspected this practice on the 3 December 2014 as part of our comprehensive inspection programme.

We found that the practice had made provision to ensure care for people was safe, caring, responsive, effective and well led and we have rated the practice as good overall.

Our key findings were as follows:

- Patients told us they were satisfied with the overall friendliness and behaviour of all staff. They described the doctors and nurses as professional, competent, thorough and knowledgeable about their treatment needs. They described the reception staff as helpful and caring.
- The practice offered flexible appointment times. Appointments were available to book in advance. The practice also offered telephone consultations and an online appointment and prescription service.
- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found that these values were embedded within the

culture of the practice. There were good governance and risk management processes in place. We found that the provider listened to patient comments and took action to improve their service.

- We looked at how well services were provided for specific groups of people and what good care looked like for them. We found that the practice actively monitored the needs of patients. We saw that arrangements were in place for older patients and patients who had long term health conditions to be regularly reviewed and to attend the practice for routine checks. We found that appointments provided flexibility for patients who were working.

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

- GPs had completed Level 2 training in safeguarding children but level 3 is recommended.
- There was no written protocol to advise staff of the actions to take following a breach of the cold chain in the storage facilities for vaccines. A record of the action that had been taken following a breach had not always been completed.

Summary of findings

- Whilst staff we spoke with had an understanding of the measures to take to minimise the risk of cross infection the majority of staff had not received infection control training.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe. 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. There were enough staff to keep people safe.

GPs had completed Level 2 training in safeguarding children and had a good understanding of the processes to protect children however level 3 training is recommended. There was no written protocol to advise staff of the actions to take in the event of a breach in the cold chain in relation to the storage facilities for vaccines. A record to evidence the action that had been taken following a breach of the cold chain had not always been completed. Whilst staff we spoke with had an understanding of the measures to take to minimise the risk of cross infection the majority of staff had not received infection control training.

Requires improvement



Are services effective?

The practice is rated as good for effective. 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). Patients' needs were assessed and care was planned and considered in line with current legislation. This included promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice had completed appraisals and the personal development plans for staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for caring. Data showed that patients rated the 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 that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good responsive. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical

Good



Summary of findings

Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment and urgent appointments were available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

The practice is rated as good for 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 in place and held regular practice 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 practice supported a patient participation group (PPG). Staff had received induction, regular performance reviews and attended staff meetings.

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 older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of older people. There were a range of enhanced services available, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. The practice kept a register of patients with complex needs including those with a learning disability, chronic disease or mental health problem. These patients were offered an annual physical health check. For those people with the most complex needs, the GPs worked with relevant health and 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, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Data showed that the practice performance for all immunisations was above average for the NHS Barnsley Clinical Commissioning Group (CCG). Appointments were available outside of school hours and the premises were suitable for children and babies.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as

Good



Summary of findings

a full range of health promotion and screening that reflects the needs for this age group. Within the extended hour's access scheme, additional appointments were offered early morning, two late evenings and Saturdays.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability. The practice had systems in place which alerted staff to patients who needed an interpreter and to those patients with a visual or hearing impairment. Longer appointments were provided and the practice had access to a telephone interpreting service for those who required it.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The GPs actively screened patients for dementia and maintained a list of those diagnosed and they were involved in best interests meetings for patients with a learning disability or dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Good



Summary of findings

What people who use the service say

We received 14 CQC comment cards and spoke with five patients on the day of our visit. We spoke with people from different age groups and with people who had different physical needs and those who had varying levels of contact with the practice.

Patients told us they were satisfied with the overall friendliness and behaviour of all staff. They described the doctors and nurses as professional, competent, thorough and knowledgeable about their treatment needs. They described the reception staff as helpful and caring.

The majority of patients were complimentary about the care provided by the clinical staff. They also said that their long term health conditions were monitored and they felt supported. One person described, very positively, how supported they had been with their mental health needs. Patients told us they had been given information about healthy lifestyles relevant to their health needs. All but one patient who commented told us they felt the clinical staff had listened to them during their consultation and they said they had received an efficient service.

Patients told us all the staff treated them with dignity and respect

Patients were complimentary about the appointments system and its ease of access and the flexibility provided.

Patients said that the practice was always clean and tidy.

We also received information from the National Patient Survey. The information below is taken from the 2013 GP Patient Surveys, 307 surveys which were sent out and 125 patients responded. The results showed 91% rated their overall experience of this surgery as good

The percentage of patients who were 'Very satisfied' or 'Fairly satisfied' with their GP practice opening hours was higher than national average with 91% of respondents satisfied. The Clinical Commissioning Group CCG average was 81% for the region.

Also higher than national average was the percentage of patients who would recommend the practice, were satisfied with phone access and who reported good overall experience of making appointment.

There were few results which were below the regional average. For example, 43% of respondents with a preferred GP usually get to see or speak to that GP compared to CCG (regional) average of 59%, 83% of respondents had confidence and trust in the last nurse they saw or spoke to compared to CCG (regional) average of 88% and 79% of respondents say the last nurse they saw or spoke to was good at listening to them CCG (regional) average of 82%.

Patients we spoke with on the day of the inspection told us that they could book to see the same GP and some had seen the same GP for many years. They also spoke positively about the nurses.

Areas for improvement

Action the service SHOULD take to improve

GPs had completed Level 2 training in safeguarding children but level 3 is recommended.

There was no written protocol to advise staff of the actions to take following a breach of the cold chain in the storage facilities for vaccines. A record of the action that had been taken following a breach had not always been completed.

Whilst staff we spoke with had an understanding of the measures to take to minimise the risk of cross infection the majority of staff had not received infection control training.

The Dove Valley Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC lead Inspector and a GP specialist professional advisor.

Background to The Dove Valley Practice

The Dove Valley Practice is situated within a purpose built health centre in the middle of Worsbrough. The practice also provides services at a branch site closer to Barnsley city centre at Gold Street Surgery, 1a Gold Street, Barnsley, S70 1TT. We did not visit the Gold Street branch as part of this inspection. The Worsbrough site building is owned by a NHS Local Improvement Finance Trust (LIFT) and the Gold Street Surgery building is owned by practice.

The practice provides Personal Medical Services (PMS) for 11,317 patients under a contract with NHS England, Barnsley.

The clinical staff team work across both sites. There are four male and four female GPs at the practice, two practice nurses including a nurse practitioner and two health care assistants. An experienced team of administrative and reception staff support the practice at both sites. This team includes a practice manager, a senior receptionist and reception coordinator and nine reception staff, one secretary, a data input clerk, one administration assistant and a domestic assistant.

The reception opening hours at the Worsbrough site are 8 am until 6.30pm on Monday, Tuesday, Wednesday, Thursday & Friday. Gold Street Surgery Reception Opening Hours are from 8 am until 6.30pm on Monday, Tuesday, Wednesday & Friday and 8 am until 4.30pm on Thursday.

Patients can access the appointment system by telephone, presenting at reception or on line via the practice web site. Some appointments are pre-bookable and some are allocated to be booked on the same day. A Duty Doctor is on call each day to see or advise patients who need to be dealt with as emergencies.

Within the extended hours access scheme, additional appointments are offered at the Worsbrough site, Monday, Wednesday and Friday 7.30am to 8 am, Thursday 7.10 to 7.30am and Monday and Thursday 6.30 pm to 7.30 pm.

Saturday morning appointments are available at the Gold Street Branch 8.30 am to 12.30 pm.

Out of Hours services are accessed by calling 111.

The Dove Valley Practice is a training practice for both medical and nursing undergraduates from the Sheffield Universities and GP trainees from the Barnsley Vocational Training Scheme.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Detailed findings

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 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.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as the NHS Barnsley CCG, to share what they knew.

We carried out an announced visit on 3 December 2014. During our visit we spoke with a range of staff including two GPs, a practice nurse, two receptionists, a medical secretary, a data input assistant, the reception coordinator, a domestic assistant and the practice manager. We also spoke with five patients who used the practice.

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We reviewed 14 CQC comment cards where patients and members of the public had shared their views and experiences of the practice. We also reviewed records relating to the management of the practice.

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 and comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. We saw electronically stored records which showed the practice had managed incidents consistently over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Significant events analysis was a standing item on the weekly clinicians and monthly practice meeting agenda. There was evidence that the practice had learned from these events and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise issues for discussion at the practice meetings.

The practice manager showed us the system they used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. Records of action taken were also maintained. We saw evidence where an incident had led to a further audit of referrals to secondary care services, such as the acute hospital. As a result when patients had been referred to secondary care services they were monitored to ensure they had been seen. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken. We saw that, where applicable, action had been taken to protect patient's health and welfare.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that the majority of staff had received training on safeguarding both adults and children. We asked members of medical, nursing and administrative staff about their most recent training. Staff

knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details of relevant agencies were available and easily accessible for all staff.

The practice had a designated lead GP in safeguarding vulnerable adults and children. The training log showed six GPs had completed online training within the last 12 months. We were told that safeguarding training was provided to all staff annually. However, the level of safeguarding training provided was not recorded. For example, level 1 training is suitable for most non-clinical staff and level three training is recommended for GPs and those staff with a safeguarding lead role. Following a discussion with their training provider, the practice manager told us that the training completed by staff was level 2.

Staff we spoke with were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic patient record system. This included information to make staff aware of any relevant issues when the patient attended an appointment. These safeguarding alerts were added to patient's records when information became known to the practice.

The safeguarding lead attended child protection meetings for children registered at the practice and completed the relevant reports. The GPs also had access to the children's and family service that were located within the health centre.

There was a chaperone policy in place, and this was displayed in the practice. One of the nursing staff and two health care assistants had been trained to act as chaperones. The practice manager and four receptionists had also undertaken chaperone training in 2010. We were told that reception staff did not chaperone patients at the Worsborough site.

Medicines management

Medicines were kept in a secure storage area, which could only be accessed by clinical staff.

Are services safe?

Any changes in guidance about medicines were communicated to clinical staff by the practice manager.

We checked the refrigerators where vaccines were stored. We looked at a selection of the vaccines stored and found they were within the expiry date. Logs of the temperature checks of the fridges used to store vaccines were maintained. Maintaining vaccines within the cold chain recommended temperatures of two to eight degrees centigrade ensures compliance with the manufacturer's license and minimises the risk of compromising the effectiveness of vaccination. However, we saw that the temperature of one fridge had risen above the recommended maximum temperature, to 13 degrees centigrade, on frequent occasions during October and November 2014. A nurse told us that recent increased temperatures had been due to the amount of stock stored for the flu vaccination programme. They told us, and we saw, that a new fridge had been purchased to alleviate this problem. We also saw that the fridge temperatures had risen above the recommended guidelines, to 9 degrees centigrade, on frequent occasions in the last 12 months. A record of the action taken on these occasions had not always been recorded. The nurse we spoke with was aware of the process to take to ensure the effectiveness of the vaccines and assured us appropriate action had been taken. We found that there was no written protocol to advise staff of the actions to take in the event of a breach in the cold chain. Following the inspection the manager conducted a significant event investigation in relation to the fridge temperatures. They provided CQC with written information as to the actions that had been completed since the inspection to safeguard the health and welfare of patients.

We saw that medicines for use in emergencies were accessible to staff. We saw these medicines were in date and the staff told us these were routinely checked. However records were not maintained to evidence the frequency of the checks and any actions taken in response to findings.

Requests for repeat prescriptions were taken by e-mail, online, post, via the local pharmacy or at the reception desk. To minimise risks, ordering prescriptions via the phone was not encouraged. A member of the administration staff team generated repeat prescriptions. They were authorised to generate a prescription for a small

number of items such as wound dressings requested by a district nurse. Repeat prescriptions were signed by a GP and checks were made to ensure the correct person was given the prescription.

There were procedures in place for GP reviews and the monitoring of patients on long term medicine therapy. We saw that health check due dates were documented on prescriptions to remind patients to book an appointment.

We saw information relating to prescribing data for the practice. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice which identified prescribing at the practice was within expected levels. We saw that the practice had participated in the local prescribing incentive scheme.

A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support as well as updates in the specific clinical areas of expertise for which they prescribed.

Cleanliness and infection control

The Worsbrough site building is owned by a NHS Local Improvement Finance Trusts (LIFT) and they are responsible for the maintenance and cleaning of the building.

We observed the premises at Worsbrough to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. The domestic staff told us regular audits of the standards of cleaning were completed. Domestic staff we spoke with were knowledgeable about their role and we saw appropriate equipment was provided. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control. Staff we spoke with were aware of the procedures in place to minimise the risks of cross infection. However, the training log showed that only eight staff of the 28 staff working in the practice had received any infection control training. The practice manager told us they had been unable to secure any infection control training. They said they would purchase an online training package to meet this need.

The manager told us that audits of infection control and cleaning standards had not been completed by the practice at either site. They told us that a nurse was responsible for checking infection control standards were

Are services safe?

maintained. However no records of these checks were completed to evidence the frequency, the tasks undertaken or actions taken in response to findings. We saw that infection rates had been considered as part of a minor surgery audit completed in 2010/11. This showed that of the 73 patients that had a minor surgical procedure, within this timeframe, one patient had developed an infection.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these. For example reception staff were able to describe, and we observed, the process for receiving samples from patients at the reception.

Hand washing sinks, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a process for the management and testing of legionella (a bacterium found in the environment which can contaminate water systems in buildings). The practice manager told us the landlord was responsible for completing Legionella checks at Worsbrough. However we saw records that confirmed the practice was carrying out regular checks to reduce the risk of infection to staff and patients at Gold Street Surgery.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly.

Staff we spoke with were aware of how to access equipment in an emergency and we observed that emergency equipment was easily accessible to staff.

Staffing and recruitment

The practice had a very basic recruitment policy and procedure. This did not identify any of the checks that were required for recruitment of clinical and non-clinical staff or the process to be followed to obtain these checks. For example, it did not include the type of proof of identification required, number of references, checking registration with the appropriate professional body or criteria for criminal records checks through the Disclosure and Barring Service (DBS). However, in all but one of the staff files, we saw relevant checks had been completed. For

the most recently employed member of reception staff only one reference had been received although two had been requested. The practice manager told us they had posted a second request for this reference.

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

GPs told us they operated a "buddy" system at the practice to cover on call duties. For example, one doctor is on-call and another is the "buddy" providing back up in case the on call doctor has to do an emergency visit or is overwhelmed by the number of patients who require an appointment. In these circumstances the other GP would stay with the on-call GP until all the work is cleared.

If two doctors are off at same time we were told surgery times would be extended in that week

We received positive comments about the staff and patients told us they found all the staff to be caring and helpful.

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 annual and monthly checks of the building, the environment, dealing with emergencies and equipment.

Risks were assessed and rated and actions to reduce and manage the risk were recorded. For example, we saw that a fire risk assessment had been completed and was reviewed annually. We saw that regular fire alarm checks were completed and recorded and staff had received fire safety training. We also saw that a risk assessment to check compliance with the Disability Discrimination Act 1995, was completed annually.

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that the majority of staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator.

Emergency medicines were available in a secure area of the practice and staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and

hypoglycaemia. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice.

For emergencies in the surgery, the reception staff had a list of things they had been told to interrupt doctor with. We were told, if possible, patients would be taken into treatment room and the doctor would be informed. There was also a protocol for calling ambulances for patients.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told clinicians held weekly practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. We were also informed the practice had a shared drive on the computers where latest guidelines and protocols were kept. GPs had personal responsibility for specific clinical areas and it was their responsibility to update practice protocols, templates and complete appropriate audits. Where there were any updates the new protocol would be added to the shared drive.

The GPs told us they were practice leads in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. One clinician told us that the doctors who were training at the practice had a formal topic based tutorial once a week and the training included new NICE guidance.

We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate. The staff we spoke with, and the evidence we reviewed confirmed, that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

The data from the local Clinical Commissioning Group (CCG) relating to the practice's performance for antibiotic prescribing was comparable to similar practices.

All GPs we spoke with used national standards for the referral of patients with suspected cancers to be referred and seen within two weeks. Administration staff were able to describe the process for ensuring patients were referred in a timely manner and how they followed up patients who did not attend for appointments following an urgent referral.

Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and 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. For example, we were told that the practice had collected information relating to the number of patients in nursing homes. They had then used this information to secure funding for additional clinical staff to support patients in nursing homes.

The GPs told us their clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. We saw examples of clinical audits which had been completed. One of the completed audits compared the management of patients with heart failure compared with an audit undertaken 12 months previously. This indicated improvements in medicines prescribing and a reduction in the number of patients who smoked. They had also identified further areas for improvement in the care and treatment for patients including increasing referrals for cardiac rehabilitation. An action plan had been developed to improve these areas.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease).

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The patient record system flagged up

Are services effective?

(for example, treatment is effective)

relevant medicines alerts when the GP was prescribing medicines. The data showed a positive outcome for prescribing practice in that it was an outlier for QOF clinical targets for antibacterial under prescribing.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that the majority of staff were up to date with attending essential training courses such as annual basic life support, fire safety and safeguarding adults and children. However we saw that the majority of staff had not received any recent training in infection control.

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

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with non-clinical staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, a receptionist been trained as a prescription clerk, and a health care assistant who wanted train to be a registered nurse was supported to take the open university route towards this.

As the practice was a training practice, doctors who were training to be qualified GPs had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with. They told us that they could approach any of the GPs for advice and support and felt that the weekly meeting also provided support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. They told us they were well supported by the GPs and had time to attend regular study

days and had time for personal development. A nurse we spoke with told us they were part of a practice nurse's forum within the local CCG area which met on a monthly basis.

Staff files we reviewed showed that where performance issues had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The staff we spoke with understood their roles and responsibilities in passing on and/or reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. Administration staff told us they tried to ensure that communication from secondary care providers, such as hospital discharge letters, went back to referring or responsible doctor.

The practice held multidisciplinary team meetings weekly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in a shared care record.

We were told that if patients did not attend a hospital appointment the practice would send out a letter asking the patient to make an appointment to discuss this with their GP.

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. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their

Are services effective?

(for example, treatment is effective)

chosen hospital). Staff told us that where patients would not be able to access this system they would book the appointment on behalf of the patient and send them a copy of their appointment.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children Acts 1989 and 2004 although we saw from the training log that training in this area was not provided. The clinical staff we spoke with understood the key parts of the legislation and told us they were often involved in best interests meetings for patients with a learning disability or dementia.

Clinical staff we spoke with demonstrated a clear understanding of Gillick competencies although the practice did not have a written protocol to support staff in their decisions. (Gillick competencies help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health promotion and prevention

The practice offered NHS Health Checks and was involved with local CCG bowel cancer screening programme. Patients were invited to attend by letter and also as they attended surgery. Patients confirmed that they had been invited for their health checks annually although some said they were slightly overdue this time. The practice monitored the patient attendance at health checks and had identified that some patients were overdue. This had

been discussed in meetings and they had put an action plan in place to address this. Two patients told us that their health check had led to a positive outcome for them as their doctor had identified a potentially serious health problem and had referred them promptly for treatment.

The practice had numerous ways of identifying patients who needed additional support. For example, the practice kept a register of all patients with a learning disability, chronic disease or mental health problem and these patients were offered an annual physical health check. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were receiving end of life care and supportive end of life care specialist clinics were offered.

The practice also offered cervical cytology. Patients were sent for centrally and if they had not attended the practice would invite them to attend. Examples of other clinics to support patients included antenatal, anticoagulation, contraception, diabetes, weight management and psychological therapies.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Data showed that the practice performance for all immunisations was above average for the NHS Barnsley CCG.

The practice web site provided access to patient information and links other websites such as Patient UK, NHS Patient Information and Royal College of General Practitioners (RCGP) Patient Information. A range of health information leaflets were also displayed in the practice waiting area. Patients we spoke with told us they been provided with information about healthy living during consultations.

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 307 surveys sent out they received 125 responses. We also looked at a survey of patients undertaken by the practice's patient participation group (PPG), 570 surveys were sent and 544 responses were received. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 91% of patients rated the practice as good or very good which was above average when other practices NHS Barnsley CCG. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 88% of practice respondents saying the GP was good at listening to them and 88% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 14 completed cards and the majority were positive about their experience of the service. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. We observed that the reception and waiting area was shared with other services although the practice has its own dedicated area. The reception area, as a whole, was quite

small and patients waiting would be able to hear what was being said to the receptionist. We observed the reception staff to be discreet when speaking to patients and there was a room in reception available for patients to speak to staff in private if they wished.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. The majority of staff had received customer care training which had included conflict resolution. We observed reception staff to be calm and helpful despite the reception area being extremely busy. The practice manager told us they had identified that the reception had become very busy at certain times in the day and were considering options to relieve the situation.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 78% of practice respondents said the GP involved them in care decisions and 83% felt the GP was good at explaining treatment and results. Both these results were above average compared to CCG area.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. The majority of patients we spoke with and those who responded on the CQC comment cards also told us they felt listened to and supported by staff. They said they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. One person told us they felt they hadn't been listened to when describing their symptoms in the past but felt the doctors had done as much as they could at the time to establish the causes of their discomfort. Another felt their relative hadn't been listened to which they felt had delayed their diagnosis. We saw that where there had been any delays in diagnosis these had been reported and investigated and learning had been shared within the practice.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required. One patient described the support they had received with their mental health needs over the years as brilliant. They told us they had also been signposted to other services which had offered them the support they required.

Notices in the patient waiting room, on the TV screen and patient website also told people how to access a number of support groups and organisations. For example, written information was available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP would contact them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

One GP at the practice was a member of the local CCG board and the Local Medical Committee (LMC). The practice provided feedback to the CCG and LMC when patient's needs were not being met. The most recent feedback to the CCG was about the data relating to numbers of nursing home patients in the area. The practice had then used this information to secure funding to improve services to nursing homes.

The practice had also acted upon results from the practice survey. The results had been disseminated to the patient forum for their consideration and comment. The information on the practice website showed this group felt satisfied with the answers given by the patients and agreed that the overall results were satisfactory. It was decided that to address the issue of high numbers of patients continuing to use the telephone to book appointments, notices would be displayed in surgery waiting areas informing patients about online booking. They found from the responses from patients that some of the attendance at the accident and emergency department in the past six months may not be warranted and the problem could have been dealt with at the practice. The GPs reviewed all accident and emergency letters and contacted the patients if they felt they should have visited the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, the practice had systems in place which alerted staff to patients who needed an interpreter. Double appointments would be booked for these patients and the practice had access to a telephone interpreting service. A similar alert was in place for patients with visual impairment and clinicians would go into the waiting room to meet the patient. Patients who had a hearing impairment were also identified and these patients were given longer appointments. We were told the practice had a hearing loop at the branch surgery and staff would try and book appointments for patients who required this equipment at that surgery.

The GPs told us they were often involved in best interests meetings for patients with a learning disability or dementia. They said they actively screened patients for dementia and maintained a list of those diagnosed. The practice was also participating in Direct Enhanced Services (DES) for patients with a learning disability. They had identified patients with a learning disability, maintained a register of these patients and offered them an annual health check. .

The practice at Worsbrough was situated within a purpose built health centre which was suitable to meet the needs of people with disabilities. The patient areas were all on the ground floor, the doors into the building opened electronically and the patient areas were sufficiently spacious for a wheelchair user.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms.

Access to the service

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey where from 307 surveys sent out they received 125 responses. This indicated the patients were generally satisfied with the appointments system at the practice.

For example, 85% of respondents described their experience of making an appointment as good which was higher than the local CCG average of 72% and 91% of respondents were satisfied with the surgery's opening hours compared to the regional CCG average of 81%. Patients we spoke with told us they could usually get an appointment for the GP of their choice although they may have to wait up to a week sometimes for an appointment to see a specific GP.

Patients could access the practice using the telephone or by presenting at reception. Some appointments were pre-bookable and some were allocated to be booked on the same day. A duty doctor was on call each day to see or advise patients who needed to be dealt with as emergencies. Extended hours appointments were available and these included appointments early morning, late evening and Saturday mornings.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and

Are services responsive to people's needs?

(for example, to feedback?)

how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. Home visits were made to local care homes as required and to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system on the web site and displayed in the practice. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at complaints received in the last 12 months. We saw that complaints had been dealt with in a timely way and patients had received a response which detailed the outcomes of the investigations. We saw that learning from complaints was shared with staff.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and where themes had been identified action had been taken. For example, during the review period the practice had received complaints regarding the reception staff. The complaints included the receptionists' attitude and appointments being made incorrectly. Customer care training had been provided to address these issues.

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. The vision and practice values were documented in the practice statement of purpose. The practice vision and values included aims to provide a professional family doctor service in a friendly, caring and efficient way and to provide the highest quality of health care to patients by giving access to a team of professional health care specialists who work together to benefit patient needs. .

Our discussions with staff and patients indicated that these visions and values were embedded within the culture of the practice.

Governance arrangements

We found there was a well-established management structure with clear allocation of responsibilities and all the staff we spoke with understood their role. We found that the senior management team and staff looked to improve the service being offered. All the staff we spoke with felt that the practice delivered a high quality of service.

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

The practice had a number of policies and procedures in place to govern activity and these were available to staff.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, the GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the QOF. One of the completed audits we saw compared the management of patients with heart failure compared

with an audit undertaken 12 months previously. This indicated improvements in medicines prescribing and a reduction in patients who smoked. They had also identified further areas for improvement in the care and treatment for patients including increasing referrals for cardiac rehabilitation. An action plan had been developed to improve these areas.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, we saw that a fire risk assessment had been completed and was reviewed annually. We saw that regular fire alarm checks were completed and recorded and staff had received fire safety training.

We found that there were some systems in place to monitor processes but some areas would benefit from more formal systems of monitoring and record keeping. For example, monitoring infection standards, recording action following a vaccine fridge cold chain breach and recording the checks of emergency medicines.

Leadership, openness and transparency

The practice held regular practice meetings. We looked at the minutes from the last two meetings and found that performance, quality and risks had been discussed.

We saw from minutes that team meetings were held regularly, at least monthly and clinical meetings were held every week. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. For example, the practice reviewed complaints annually to detect themes or trends.

The practice had an active virtual patient participation group (PPG) which had steadily increased in size. The PPG included representatives from various population groups including 65 female and 39 male representatives across various age groups. These numbers also included 15 disabled representatives. The PPG had been involved in planning the annual surveys, reviewing the feedback and agreeing the action plan. The practice manager showed us

Are services well-led?

Good 

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

the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice was a GP training practice. The practice trained junior doctors who are on the Barnsley Vocational Training Scheme. This is a three-year course which doctors can embark on after two years in (Foundation) hospital jobs. It constitutes 18 months in General Practice and 18 months in hospital specialities like paediatrics, obstetrics and gynaecology and psychiatry.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example, we saw evidence where a one incident had led to a further audit of referrals to secondary care such as the hospital. As a result when patients had been referred to secondary services they were monitored to ensure they had been seen or had further management.