

Shafton Lane Surgery

Quality Report

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Date of inspection visit: 21 October 2014

Date of publication: 05/03/2015

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 service on the 21 October 2014 as part of our new comprehensive inspection programme. We have rated the practice as good.

Our key findings were as follows:

- Lessons were learned and improvements were made when things went wrong.
- Patients were supported to live healthier lives.
- Patients told us they were treated with kindness, dignity and respect whilst they received care and treatment.
- Services at the practice were planned and delivered to take in to account of the needs of different patients.
- Staff understood their role in achieving a patient focussed service.

There were areas of practice where the provider needs to make improvements.

- The practice sought to improve patient care and outcomes through audit. However, there was no evidence to show that changes were implemented within the practice as a result of the clinical audits cycles.

Importantly, the provider must:

- Ensure that its recruitment process covered the essential checks for all new starters, such as Disclosure and Barring Service (DBS) checks prior to employment.

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?

Some aspects of the service were safe, however there are some requirements that were needed to ensure the practice was safe. Lessons were learned and improvements were made when things went wrong. Systems, processes and procedures were in place to keep patients safe and safeguarded from abuse. Arrangements for managing medicines were in place. The practice was visibly clean and well-maintained. There were systems in place for the maintenance and use of equipment. Staffing levels and skill mix were planned and reviewed at the practice.

The practice had a recruitment policy in place, however it did not cover essential checks such as Disclosure and Barring Service (DBS) checks prior to employment.

Requires improvement



Are services effective?

Some aspects of the service were effective. Care and treatment was considered in line with current published best practice. Patients' needs were met and referrals to secondary care were made in a timely manner. Staff had the skills, knowledge, qualifications and experience to deliver effective care and treatment. Staff and services worked together to deliver effective care and treatment. Patients' consent to care and treatment was always sought in line with legislation and guidance. Patients were supported to live healthier lives.

We saw evidence that the practice sought to improve patient care and outcomes through a systematic review of care against audit criteria. The GP could provide examples of how audits had identified trends. However, the audit results did not record actions to be taken to make improvements.

Good



Are services caring?

The service was caring. Patients told us they were always treated with kindness, dignity and respect when they received care and treatment. Patients who used the practice and relatives were routinely involved in planning and making decisions about their care and treatment. Patients we spoke with told us they received appropriate and timely support to cope emotionally with their care and treatment.

Good



Are services responsive to people's needs?

The service was responsive to patients' needs. Services at the practice were planned and delivered to take in to account the needs of different patients. Referrals to secondary care and sign posting to

Good



Summary of findings

services such as weight management, Leeds Lets Change and Alcohol Dependency Service (ADS) were made in a timely way. Patients had mixed views about accessing an appointment. Patient's concerns and complaints were listened to and responded to by the practice

Are services well-led?

The service was well led. Staff understood their role in achieving a patient focussed service. There were some systems in place and the practice was making improvements to monitoring the process of how care was provided. Leaders at the practice were visible, approachable, encouraged openness and transparency and promoted good quality care. Patient's and staffs views and experiences were gathered and acted on to shape and improve the service and the culture of the practice. A proactive approach was taken to involve and seek feedback from patients and staff.

Good



Summary of findings

What people who use the service say

We received 34 completed Care Quality Commission (CQC) patient comment cards and we spoke with four patients on the day of our inspection visit.

The patients spoke positively of the care provided by staff; their professional manner, responsiveness to their needs and overall they told us they were always treated with dignity and respect. The majority of patients said they were involved and felt supported in the planning and decision making of their care. They felt the clinical staff responded to their treatment needs and they were given a caring service. They told us that the staff were kind hearted, caring, helpful, understanding, friendly and they felt listened to. Patients told us that the practice was always clean and tidy. Overall they felt the practice provided a good service and they were satisfied with their care.

Patients reported that they were given support and information about any care or treatment and were provided with leaflets. Patients said the service generally met their needs. They explained that improvements could be made to the appointments system and said that it was sometimes very difficult to get an appointment as they had to call the practice at 8.00 am and most appointments were gone or they had to wait a long time when the practice held an open surgery. The practice manager told us that they had extended the locums appointments from 12 to 18 appointments to try and accommodate patient's needs.

Prior to the inspection we received information from HealthWatch. HealthWatch is an organisation which voices patient's concerns and provides feedback to service providers and commissioners. Through local engagement they collect vital data on how and why patient use services in their area. They told us that they had received 5 comments from patients between March and August 2014 regarding the care received by patients

and access to appointments. They told us that four of the comments were negative, for example appointments weren't dealt with on time, appointments were delayed and also around misdiagnosis of a condition. One positive comment told us that the practice provided nice and wonderful hospitality and staff were caring and provided good treatment.

The national GP patient survey results in 2013 stated the practice was found overall to be as expected nationally with some areas requiring improvements. We saw 72 percent of patient's experience of making an appointment as good or very good, 68 percent said it was easy to get through to someone at the GP practice on the phone.

We saw the results stated the practice was found to be among the worst nationally with only 68.7 percent of patients saying they would recommend their GP surgery. Eighty per cent of patients overall rated their experience of the GP surgery as good or very good.

We found the results to be worse than expected nationally 71.1 percent for opening hours. The practice acknowledged that the appointment system needed improvements to meet patient's needs. They told us they were looking at options to improve the flexibility of the appointment system, such as becoming part of Leeds 11 federation or working in partnership with local practices to enable them to extend the opening hours and as part of winter planning.

The results also outlined what the practice did best which included; 93 percent of respondents found the receptionists at the practice helpful, 95 percent of patients had confidence and trust in the last nurse they saw or spoke to, 77 percent of patients said the last nurse they saw or spoke to was good at involving them in decisions about their care.

Summary of findings

Areas for improvement

Action the service **MUST** take to improve

- The practice had a recruitment policy in place, however it did not cover essential checks such as disclosure and barring service (DBS) checks prior to employment.

Action the service **SHOULD** take to improve

There was no evidence that changes were implemented within the practice as a result of the audits.

Shafton Lane Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead inspector and a GP.

Background to Shafton Lane Surgery

Shafton Lane Surgery is located in Holbeck, Leeds and provides primary care services to 2,900 patients. There is disabled access at the front of the practice, a car park with allocated disabled parking spaces and street parking is also available.

The service is provided by one full time female GP and one regular male part time locum. Working alongside the GP is a part time female practice nurse, a part time female health care assistant and a female health trainer. There is an experienced management team and four administration and reception staff employed to support the practice.

The practice has a General Medical Service (GMS) contract in place. A GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The practice is open Monday to Friday 8:00 am to 6:00 pm. There is a range of appointments available including, on the day, book in advance, open surgery, telephone consultation and urgent appointments are triaged to the GP who will decide if they need to see the patient on the same day. Patients are able to book these in person or over

the phone. The practice also offers home visits for patients who are unable to attend the practice. Out of hours services for the practice are provided by Leeds out of hour's service.

The healthcare assistant works in conjunction with the practice nurse to provide clinics for patients at the practice. These include vaccinations and immunisations, cardiovascular checks, NHS health checks, phlebotomy, weight management, baby clinics, chronic disease management such as asthma, Chronic Obstructive Pulmonary Disease (COPD), heart disease and child immunisations. The practice also has a health trainer who provides sessions to support patients in weight management, exercise and smoking cessation.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

Detailed findings

- Vulnerable older people (over 75s)
- People with long term conditions
- Families, children and young people
- Working age population (including those recently retired and students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before visiting Shafton Lane Surgery, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. We asked the practice to provide a range of policies and procedures and other relevant information before the inspection to allow us to have a full picture of the practice.

We carried out an announced inspection visit on the 21 October 2014. During our inspection we spoke with a range of staff including a GP, a locum GP, a practice nurse, a locum nurse, a health care assistant, receptionists, the practice manager and deputy practice manager. We spoke with patients who used the service. We observed positive interactions between staff and patients at the reception area during their visit to the practice. We reviewed CQC comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe Track Record

The practice demonstrated it had a safe track record. The practice used information from different sources, including patient safety incidents and complaints to identify trends. 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 and the practice held regular multidisciplinary case review meetings where all patients on the palliative care register were discussed. Safety was monitored using information from a range of sources including QOF and patient survey results.

We looked at the significant events for the last 12 months and saw that there had been seven. The records showed that most staff had been involved in the learning, and the practice were appropriately reporting and investigating incidents and action had been taken.

The practice held a multi-disciplinary meeting every two months with attendance from the GP, community matron, district nurse, palliative care, adult social care worker and a member of the Holbeck Elderly Aid. Information relating to risk factors for the patients' health and welfare was shared and action plans developed to minimise risks were agreed.

Learning and improvement from safety incidents

The practice demonstrated that lessons were learned and improvements were made when things went wrong. We spoke with reception staff, a practice nurse, a locum nurse, a healthcare assistant, the deputy practice manager and the practice manager who were able to give examples of incidents and the lessons that were learned. We were told, and we saw from records, incidents were investigated and then discussed at all levels of the practice and any learning points were actioned.

Staff we spoke with were clear and understood their responsibilities to raise concerns, to record safety incidents, accidents, concerns and near misses, and to report them internally and externally where appropriate. They were able to give examples of incidents that had occurred and the process they would follow to report incidents. For example,

a system had been put in place to ensure that all patients that use an inhaler, received a new device annually. The team recognised the benefits of identifying any patient safety incidents.

We saw evidence that incidents were discussed with both clinical staff in regular staff meetings. Non clinical staff told us that incidents were discussed at their reception staff meeting. We were able to review minutes of the meetings and saw that changes had been made as a result of incidents that had occurred to improve safety. Staff were able to tell us how practice had changed to minimise risks of reoccurrence following incidents. For example, a staff member described how practice had been changed for the management of repeat prescriptions following an incident involving the collection of prescriptions.

Reliable safety systems and processes including safeguarding

The practice had reliable systems, processes and practices in place to keep patients safe and safeguarded from abuse. There were arrangements in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. The practice had a safeguarding policy in place. The policy detailed the steps that staff members should take if they suspected a person may be at risk from abuse. This included the escalation process within the practice and also provided contact details for external agencies. The staff we spoke with were clear and understood their responsibilities to keep patient safe and how to escalate concerns regarding safeguarding. Flow charts were displayed prominently throughout the practice with relevant contact details with external agencies and the action to take in the case of suspected abuse.

The majority of staff had attended training in safeguarding children and adults. The GP and practice nurse had completed safeguarding children levels two and three training. The GP was the named safeguarding lead for the practice. The GP told us that they attended child protection meetings which were kept in the patient's record. They told us that they received a task on the clinical system to follow up on children who may be at risk who attended the hospital for treatment.

We spoke with the practice manager and deputy practice manager who told us that they held a list of patients on the clinical system where safeguarding concerns had been suspected.

Are services safe?

There was also an informative safeguarding adults and children's display board in the waiting room which sign posted patients to useful services such as the National Society for the Prevention and Cruelty to Children (NSPCC) and the Samaritans.

From our observations during the inspection visit, discussions with patients, staff and from CQC comment cards we found the design, maintenance and use of facilities and premises kept patients safe. We found the waiting area to appear tired in terms of décor. One patient told us that the premises were a bit shabby rather than dirty. However, we observed that the treatment rooms had been modernised. We also found the equipment had been calibrated and PAT tested.

Medicines Management

The practice had arrangements in place for managing medicines to keep patients safe, which included obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal. Medicines were kept in a secure store, which could only be accessed by clinical staff. There were equipment bags ready for doctors to take on home visits. We checked the contents of the bag and found the medication and diagnostics to be in date.

We checked the refrigerators where vaccines were stored. We saw that 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 deputy practice manager was responsible for carrying out both temperature and stock control checks.

We saw on the practice web site, practice leaflet and discussions with the practice manager and deputy practice manager that patients could request repeat prescriptions either by online service, telephone, in person, fax or letter and prescriptions could be collected from the practice. They said this would be processed within 48 hours. The clinical system gave the GP access to up to date information and best practice guidelines when prescribing medicines for patients.

The practice had a medication review protocol in place. We saw that medicine reviews were carried out, the practice had a system and protocol in place to alert the GP to when patients were due for a medication review. The practice

had a system in place to manage and record blood test results. The GP told us that they managed the results and any actions required were carried out by the reception team. 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.

The practice received medication alerts from the Clinical Commissioning Group (CCG) or the National Institute for Health and Care Excellence (NICE). Any changes in guidance about medicines were communicated to staff via an email.

Cleanliness & Infection Control

Standards of cleanliness and hygiene were maintained at the practice. We observed all areas of the practice to be visibly clean, tidy and well maintained. We saw that the hand washing facilities, liquid soap, paper towels and instructions about hand hygiene were available throughout the practice. Couches were washable and paper couch roll was used. Cleaning schedules were available, they included the frequency of cleaning equipment..

We saw that 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 that the practice had stocks of instruments and that these were within their expiry date. We found single use equipment was in a cover for example tubing. However, the oxygen mask covering was open to the air.

The sharps bins were appropriately assembled signed and dated and were available in all treatment rooms. There was a needle stick injury policy in place. Clinical staff we spoke with were knowledgeable of what to do in the event of an injury.

The practice had an infection control policy and guidelines in place. The policy provided staff with information regarding IPC, including hand hygiene, sharps injury, Personal Protective Equipment (PPE) and dealing with spillage and bodily fluids. Staff we spoke with knew what to do in the event of a spillage. We saw that the practice had spillage biohazard packs and urine and vomit spillage kits were available.

Are services safe?

The GP was the lead for infection control in the practice. Audits of the IPC processes had been completed externally and an action plan had been developed to address any identified shortfalls.

The practice had legionella assessments in place. We saw that used outlets identified were flushed weekly for several minutes and this was recorded. The practice had suitable and sufficient risk assessments required to identify and assess the risk of exposure to legionella bacteria from work activities and water systems on the premises were checked to ensure continued satisfactory operation.

Equipment

The maintenance and use of equipment kept patients safe at the practice. 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. The sample of portable electrical equipment we inspected had date stickers on them showing the last time they were tested; each one inspected was in date. Equipment was generally clean and functional.

Staffing & Recruitment

Staffing levels and skill mix were planned and reviewed at the practice. The practice manager told us that they had a high level of staff sickness. However, they were able to manage this as there were sufficient numbers of staff employed by the practice to provide cover for sickness and holidays. The practice was also in the process of recruiting a practice nurse.

We found that there were policies and procedures in place to support the recruitment of staff although these were basic and did not cover essential checks such as Disclosure and Barring Service (DBS) and professional registration checks such as nurse's registration with the Nursing and Midwifery Council (NMC). When we looked at a sample of staff recruitment files we found some appropriate pre-employment checks had been completed. Records showed ongoing checks of staff registration with professional bodies, such as the NMC which confirmed they were able to continue to practice. However, there was no evidence that DBS checks had been undertaken for staff.

Most of the staff at the practice had been employed for a number of years. The practice manager told us that these were done during employment processes and gave assurances that they were in the process of undertaking retrospective checks for all staff. (Following the inspection the practice manager confirmed that DBS checks for all staff had been completed with the exception of the practice nurse, who had been employed since April 2006).

We were told that the practice had used a regular locum for three years to enable patient continuity. We saw that appropriate checks had been undertaken which included a General Medical Council (GMC) reference number, indemnity and a DBS check. The practice had a locum pack in place which gave the GP relevant and up to date information about the practice policies, procedures and guidelines.

Monitoring Safety & Responding to Risk

The practice managed some aspects of risk. The practice had developed clear lines of accountability for all aspects of care and treatment. The GP had 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. The practice manager told us they ensured alerts were logged and actioned taken as required.

Risk assessments were carried out for patients who used services. We saw that there were risk assessments in place such as fire, legionella and infection prevention and control. However the practice manager acknowledged that more comprehensive risk assessments were needed and would be implemented in the next three months to ensure risks were responded to appropriately.

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 had a sharps injury procedure to follow should one occur. Staff also had access to emergency equipment.

Arrangements to deal with emergencies and major incidents

Are services safe?

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 computer system and incapacity of staff.

Staff talked confidently about what to do in the event of an emergency. We found all staff were trained in Cardio Pulmonary Resuscitation (CPR) to support patients who had an emergency care need. Emergency equipment was checked and available for staff to access in an emergency.

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 that they used relevant and current evidence-based guidance such as the National Institute for Health and Care Excellence (NICE) guidelines and the British Hypertension Society to develop service, care and treatment delivery. These were applied during assessment, diagnosis, and referral to other services, management of long term conditions or chronic conditions. The practice monitored this through an electronic computer system.

Patients were supported to achieve the best health outcome for themselves, they had access to information leaflets identifying the rationale for the recommended treatment and also further health promotion advice.

Management, monitoring and improving outcomes for patients

Information about the outcomes of patients' care and treatment were routinely collected by the practice. The practice manager and deputy practice manager told us that this was done through patient survey, NHS Choices website and the Quality and Outcomes Framework (QOF). We saw that action plans were in place to monitor the outcomes and the action taken as a result to make improvements. Staff were involved in activities to monitor and improve patients' outcomes.

The practice participated in a range of applicable local audits, such as diagnosis of diabetes, recording of body mass index and management of obesity, atopic eczema, diagnosis and management of dyspepsia and headaches. We reviewed the audits and found the practice was improving the quality of patient care by looking at current practice. However, we could not find evidence that a comprehensive audit had been completed to identify problems and lead to effective changes being implemented that result in improved patient care.

The practice used the information they collected for the QOF and their performance against national screening

programmes to monitor outcomes for patients. Information from QOF showed that the practice were appropriately identifying and monitoring patients with health related problems.

Effective staffing

Staff had the skills, knowledge, qualifications and experience to deliver effective care and treatment. Staff generally received appropriate training to meet their learning needs and to cover the scope of their work. An induction programme included time to read the practice's policies and procedures. Newly employed staff were supported in the first few weeks of working in the practice. We were able to review staff training records and we saw that this covered areas such as safeguarding, health and safety, fire, dignity and respect and CPR. However there was no evidence that staff had completed training in infection prevention and control and manual handling. The practice manager told us they were in the process of updating the practices' processes and systems. They had plans to standardise the records and these included: staff recruitment, induction, appraisals and training record files to provide an accessible consistent approach to the service, which could be monitored. This would ensure staff were up to date with practices and fully supported in their roles.

Staff told us they also had access to additional training related to their role and for personal development. For example the healthcare assistant had completed training in motivational advanced consultation skills, weight management and COPD screening.

The majority of staff had not received an appraisal for two years. The practice manager told us that all staff would receive an appraisal in December 2014. Although staff had not received an appraisal they told us that they were able to informally discuss any issues or training needs with their manager. The healthcare assistant told us that they had an annual appraisal and found it very useful. The GP told us they received an appraisal and both the locum GP and the GP had received support for revalidation.

Staff told us that they felt they had opportunities to develop and were able to take study leave and protected time to attend courses.

Are services effective?

(for example, treatment is effective)

There were arrangements in place for supporting and managing staff to deliver effective care and treatment. Reception staff had monthly team meetings with the practice manager where they could openly raise any concerns or issues.

Working with colleagues and other services

Staff and services worked together to deliver effective care and treatment. The practice regularly worked with other health and social care providers and professional bodies to co-ordinate care to meet patient's needs, such as the walk-in-centre, minor injuries centre, Holbeck Elderly Aid and Age UK.

Care at the practice was delivered in a coordinated way during out-of-hours care. The practice was supported with out of hour's provision from Leeds out-of-hours service. This assisted with patients who could not access appointments during usual surgery hours to obtain GP treatment. Following the patient use of the service the GP's at the practice reviewed any correspondence from them. This ensured the practice was aware of any treatment that had taken place and if any follow up care was needed.

The practice used a clinical system, which enabled staff to complete a number of tasks electronically. This system enabled staff to communicate that a task was required to be completed. For example, reception staff could send a task to the GP to review repeat prescription requests and the GP could send a referral task to reception staff. This system also enabled timely transfer of information with out of hour's services.

The practice had clear arrangements in place for referrals to other services. Patients told us that they were given a choice of which hospital they would like to be referred to. Patients could use the choose and book system to access secondary care. The practice manager told us they would refer patients to a wide range of services, such as smoking cessation, dieticians, chiropody, Leeds lets change, Hamara centre (for asylum seekers) and alcohol dependency service. It was the GPs responsibility to follow up on the referrals.

Staff worked together to assess and plan ongoing care and treatment in a timely way when patients were discharged from hospital. We spoke with the practice manager who told us that discharge letters were scanned on to the patient's record.

The practice had 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.

Information Sharing

Staff had all the information they needed to deliver effective care and treatment to patients who used the practice. All patient information was recorded on the clinical system for staff to access. The clinical system colour codes staff rota's, staff can view patient appointments by day, week or staff member, move whole rota's from one clinician to another, automatically record do not attends (DNAs). This ensured all the information needed to plan and deliver care and treatment was shared appropriately and available to relevant staff in a timely and accessible way. There was a system in place to manage information about patients who used the practice to support staff to deliver effective care and treatment.

The patient records at the practice were electronic and accessible to staff. Paper records were archived in a lockable cabinet.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff were knowledgeable about how to ensure patients were involved in making decisions and the requirements of the Mental Capacity Act (MCA) 2005 and the Children's Act 1989 and 2004. We found that the GP understood how to use capacity assessments and competency assessments of children and young patients, which check whether children and young patients have the maturity to make decisions about their treatment.

The practice manager told us that staff had undertaken safeguarding training which included the application of the MCA.

The practice had an effective consent policy available to assist all staff and this contained relevant consent forms for use, along with information for patients. We saw that the consent forms were in place. Staff we spoke with told us they would ask the patient or their relative to consent to care and they would always involve them in the decision making process. The majority of patients told us they had been involved and supported in decisions about their care

Are services effective?

(for example, treatment is effective)

and treatment. Some patients said they were told what to do, but they felt listened to. They told us their treatment had been fully explained to them and they understood the information given to them.

Health Promotion & 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 person's health. Patients' individual needs were assessed and access to support and treatment was available as soon as possible. The practice employed a health trainer to support patients to live healthier lives. The sessions included; weight management, exercise and smoking cessation.

QOF information showed the practice performed well regarding health promotion and ill health prevention initiatives. For example, the practice could produce a register of patients aged 18 and over with learning disabilities and the practice had regular multidisciplinary case review meetings where all patients on the palliative care register were discussed.

The practice offered national screening programmes, such as bowel, cytology, COPD, mental health and dementia. There are also vaccination programmes, long term condition reviews and patients are provided with health promotion information. The practice provided information to patients via their website, there were comprehensive and informative noticeboards and leaflets in the waiting area.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in

offering help to support the population groups. The GP was able to tell us how they managed the care of patients with long-term conditions, older patients, patients experiencing poor mental health (including people with dementia), people in vulnerable circumstances, working age people (including those recently retired and students) and families, children and young people; what these were; and the action taken to regularly review their needs. For example patients who were on an end of life care pathway and patients with a learning disability were on the practice register, patients over the age of 75 received an annual health check and there was a weekly baby clinic for young families.

The practice also provided patients with information about other health and social care services such as Carers' Leeds services, NSPCC, Samaritans and Age UK. We saw a range of informative and comprehensive display boards and leaflets in the practice to signpost patients to these services. There was a television in the waiting room which displayed health promotion. The practice website also sign posted patients to health leaflets on the NHS Choices website. Staff we spoke with were knowledgeable about other services and how to access them.

We found staff proactively gathered information on the types of needs their patients had and staff understood the number and prevalence of different health conditions being managed by the practice. Patients who may be in need of extra support were identified at the practice, for example patients receiving end of life care are placed on the palliative care register. The practice also involved a hospice where appropriate.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients at the practice told us they were treated with kindness, dignity, respect and compassion whilst they received care and treatment. They spoke very positively about the care they received from all staff at the practice and they felt looked after.

We observed that patients could be overheard when speaking to reception staff within the reception area. However there was a TV in the reception area which created background noise to try and enable privacy for patients whilst at the reception desk and patients could also speak with reception staff in private in another room if required.

Staff we spoke with were able to provide us with examples of the steps they needed to take to protect patient's dignity, such as using a consulting room should patients wish to speak in private with a member of staff, private conversations with patients by telephone would be done in the privacy of the back office. They said that they had access to language line should they need it. Staff also had access to health leaflets, recall and screening letters in different languages. During our observations of the reception area we saw staff treated patients with dignity and respect.

Staff provided us with examples of how privacy and dignity was always respected during physical or intimate examinations. They said they would ensure the door was locked and offer a sheet for patients to cover themselves. We were told that the practice nurse appointments had been reduced from 15 minute appointments to ten minutes. The practice nurse said they would prefer longer appointment slots so they had more time to interact with patients who used the services. We had a number of comments from patients who told us that the GP's took their time to listen to them and they always got the advice and care they needed.

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. All of the reception team had received chaperone training.

Care planning and involvement in decisions about care and treatment

The majority of patients who used the practice and their relatives were routinely involved in planning and making decisions about their care and treatment. We received comments from patients that they got the advice they needed from the GP and they were also provided with leaflets to support them with conditions. We spoke with the GP who said that every consultation involved discussing the patient's management plan and providing them with leaflets. Information from QOF showed that the practice had a register for patients who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate.

We found that staff communicated with patients so that they understood their care, treatment or condition. We received comments from patients that they understood their treatment and options were discussed during their consultation.

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, and enable them to access this. Staff had access to language line interpreters, a hearing loop, signing interpreters and to health leaflets available in different formats. Recall and screening letters were also available in different languages.

Patient/carer support to cope emotionally with care and treatment

Patients who used the practice told us they received appropriate and timely support they needed to cope emotionally with their care and treatment. They said that they had been signposted to the relevant services to meet their needs.

Staff we spoke with had an understanding of the impact that a patient's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. They said there were various support mechanisms in place to ensure patients were supported, such as bereavement signposting support and counselling services.

Are services caring?

The GP we spoke with told us how they had worked closely with other agencies to support patients who were receiving end of life care who had accessed local health services. This involved regular multi-disciplinary meeting to discuss the patient's needs.

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. The practice held information about the prevalence of specific diseases. This information was reflected in the plan for the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. The practice held regular clinics for a variety of complex and long-term conditions such as asthma, COPD and diabetes. There were systems in place to ensure that patients were called for routine health checks and non-attendance was monitored and acted on through phone calls or letters to the patient.

The practice made adjustments to meet the needs of patients, including having an audio loop system sign displayed on the reception counter for patients with a hearing impairment. There was guidance about using interpreter services and the contact details available for staff to use. Staff were knowledgeable about interpreter services that were available when English was a second language for patients. Staff also told us that they were familiar with patients who may need additional support and when these patients booked an appointment they ensured additional time was allowed for the appointment.

The practice regularly sought the views of patients through the patient surveys which enabled patients to voice their concerns and needs.

The practice provided services which were planned, delivered and coordinated to take account of patients with complex needs or those with a learning disability. The practice manager explained that they involved other agencies to support patients with a learning disability.

Patients with mobility difficulties had access to the practice and there were allocated disabled parking spaces.

Tackling inequity and promoting equality

Services at the practice were planned and delivered to take in to account of the needs of all patients. The practice had made reasonable adjustments with the facilities they had so that disabled patients and patients with push chairs could access and use services on an equal basis to others. There was a ramp at the front of the practice for wheelchair access.

The practice had a register on their clinical system of patients who were in vulnerable circumstances. Patients' electronic records contained alerts for staff; for example patients who were at risk of abuse. The staff said they were able to engage with patients as it was a small practice and they had excellent relationships with patients. The practice referred patients to Leeds Lets Change service which offered support with drug/alcohol misuse and mental health.

Access to the service

Patients could access care and treatment at the practice in a timely way. The national GP survey results published showed they were performing at the national average. The patients responded about their ability to get through on the phone and they scored a middle rating of 68.2%. Patients were 72.1% satisfied with their experience of booking an appointment at the practice.

Areas that indicated a poorer response rate related to the opening hours, patients who described the overall experience of their GP surgery as good or very good and the proportion of patients who would recommend their GP surgery. As a result the practice had introduced three open surgeries and increased the number of appointments with the locum GP from 12 to 18 appointments. The practice acknowledged that the appointment system required improvements to meet patient's needs. The GP told us that they could not extend the opening hours as they did not have enough GPs to support the extended hours. They told us they were looking at options to improve the flexibility of the appointment system, such as becoming part of Leeds 11 federation or working in partnership with local practices to enable them to extend the opening hours and as part of winter planning.

Patients attending the practice could alert staff of their arrival by registering on an electronic touch screen monitor situated in reception or by notifying the staff at the desk.

During our inspection visit we made observations of the reception area, reviewed CQC comment cards and spoke with patients. We observed a patient who was told there were no appointments available on this day and the staff did not ascertain whether their appointment was urgent or not. Some patients told us they had experienced problems when booking appointments and could not always get an appointment when they called the practice at 8:00 am or they had to wait a long time when they attended an open

Are services responsive to people's needs?

(for example, to feedback?)

surgery. Other patients told us they had never had an issue in getting an appointment to suit their needs, one patient told us that they did not have to wait long and their children were always seen straight away.

Information about appointment times were displayed at the practice and on the practice website. Appointments were available for patients, which included telephone consultation with a GP where appropriate, on the day, pre-bookable, open surgeries and urgent appointments were triaged to a GP. The practice supported patients to access appointments by offering a range of mediums, such as by, telephoning the surgery or attending in person. Out of hours services for the practice were directed from the practice to Leeds out of hour's service.

Efforts were made to enable patients to access care and treatment at a time to suit them. The practice was open Monday to Friday 8:00 am to 6:00 pm. However there was only one appointment at 5.30 pm for the working population. The practice did not have any plans to extend the appointment times to meet the needs of the working population. The practice manager told us that they never cancelled GP appointments and when there were delays patients were kept informed about any disruption.

Listening and learning from concerns & complaints

Patient's concerns and complaints were listened to and responded to and used to improve the quality of care at the practice. The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Complaints were handled in line with the practice policy. The outcomes of complaints, actions required and lessons learned were shared with the staff during their team meetings.

There were systems in place for reporting and receiving complaints. We reviewed the record of complaints for the practice and saw that there had been 14 complaints within the last 12 months. Four of the complaints we reviewed were potentially progressing to clinical negligence claims. This was proportionately high for a practice which provided primary care to 2,900 patients. The GP told us that they were being investigated by NHS England.

The complaints procedure was available to patients in the practice booklet. The patients we spoke with were generally 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 practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values within the practice statement of purpose. This document stated the overall purpose of the practice was to improve the health, wellbeing and lives of those patients they care for. The practice had documented 12 aims and objectives to achieve their purpose.

We spoke with the GP and practice manager who were able to sign post us to the statement of purpose for the practice vision and values. The majority of staff we spoke with were unaware of the statement of purpose. However, they told us that safety was a priority at the practice and they had a thorough understanding of their role in achieving a patient focussed service.

The practice leaflet contained a patient charter, explaining what patients can expect from the service and what the practice expects from the patients. We also saw a poster in the reception area displaying a pledge to patient safety. It stated that the health of their patients is their first consideration, they will maintain the utmost respect for human life from the time of conception, and they will also consider religion, nationalities, race and social dignity.

The practice had monthly staff meetings. Staff told us patient safety issues were discussed at the meetings for example, incidents and complaints. 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 promoted patient safety as a priority.

We found there was a management structure with allocations of responsibilities and all the staff we spoke with understood their role.

Governance Arrangements

The practice had a basic governance framework to support the delivery of the strategy and quality care. The practice manager's role involved overseeing that the systems in place were consistently being used and were effective. They told us the practice needed a more structured

approach to their governance systems and they were engaging with a management consultancy to enable them to implement a systematic approach to governance within the next three months.

There was a clinical governance policy in place. The policy was basic and did not provide a comprehensive framework through which staff were accountable for continually improving the quality of their services. However, staff we spoke with were clear about their roles and they understood what they are accountable for.

The practice had a programme of clinical and internal audit. These were used to monitor quality and systems to identify where action should be taken. For example accidents and emergencies and do not attends (appointments) at hospitals. They told us that the DNA audit they undertook assisted them to identify the trends within the practice. They also undertook a range of local audits, such as diagnosis of diabetes, recording of body mass index and management of obesity, atopic eczema, diagnosis and management of dyspepsia and headaches. We reviewed the audits and we could not find evidence that a comprehensive audit had been completed which identified areas for improvement and the actions taken as a result. However, the GP could provide examples of how audits had identified some trends.

The practice manager told us they were in the process of reviewing the policies and procedures and they would continue to do this until they were all up to date and in line with best practice guidance.

We found that the GP had been allocated the lead roles for infection control and safeguarding. A member of the reception team had a lead role for ensuring the 24 hour blood pressure monitoring system was linked to the computer and the maintenance of the machine. Some staff were aware who had lead roles in areas such as safeguarding and infection control. They said they could approach a member of the team for advice in these areas.

Leadership, openness and transparency

We spoke with the practice manager and the deputy manager during our visit. They had been employed at the practice for a number of years and demonstrated that they had the experience to lead the team. However, the practice manager raised concerns that they do not always have the capacity or capability to always lead effectively. For example, they felt they worked excessive hours and the

Are services well-led?

Good 

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

training for management was not sufficient to support them in their roles. The practice manager had raised these concerns with the GP who had been supportive and agreed an action plan to address them.

The management team were aware of the challenges to good quality care and identified the actions needed to address them. For example improving the governance system to provide a structured framework. The practice were engaging with a management consultancy to enable them to implement a systematic approach to governance. The GP told us that one of their challenges was being a small practice, as they were the lead for everything and therefore had to attend all the Clinical Commissioning meetings (CCG).

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 always there and very approachable. 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 or they could speak with the GP. Staff spoke highly of the teamwork approach at the practice. They told us they felt very well supported, respected and valued as a team member by the management at the practice.

The culture of the practice was centred on the needs and experiences of patient who used the services. Staff told us that they always focussed on the patient's needs. The practice sought the views of the patients through the patient survey, they said this enabled patients to influence decisions and improvements made at the practice.

The culture encouraged candour, openness and honesty, with regular meetings. The majority of staff attended staff meetings and they told us that they were encouraged to voice their opinions and felt listened to. The minutes of the meetings reviewed showed that the meetings provided staff with the opportunity to discuss the service being delivered.

Staff safety and wellbeing was priority for the practice. Staff could be referred to occupational health if needed. Staff we spoke with told us that they supported each other as a team.

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

Patient's and staffs views and experiences were gathered and acted on to shape and improve the

services and the culture of the practice. The practice conducted a patient survey, we saw that an action plan was in place and improvements had been made as a result. For example, the main issues raised in the survey were around appointments and opening times. As a result the practice introduced three open surgeries per week.

The practice used to have a Patient Participation Group (PPG) but due to lack of attendance the group discontinued. The practice manager told us that they planned to reinstate a PPG at the practice so that patients had a voice. The practice website had a dedicated page advertising the PPG, how it works and how patients can join.

We received 34 completed Care Quality Commission (CQC) comment cards. The patients were very complimentary about the care provided by the all staff and the overall helpfulness and behaviour

of staff.

Staff told us they were very engaged and had a brilliant relationship with patients. They spoke about their roles and their 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 understand the value of raising concerns and they were able to raise these with the practice manager. They felt that they would be listened to and action taken where appropriate.

Management lead through learning & improvement

The practice used information to continuously improve the quality of services. Most 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. Staff told us each month the practice had dedicated protected learning time which they referred to as Time for Audit, Review Guidelines Education and Training 'TARGET' days. They told us that they were able to discuss issues and they found the experience very useful.

Are services well-led?

Good 

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

The staff we spoke with told us they felt supported to complete training and could request any additional training which may assist with their role. For example the practice nurse had recently attended training in wound care to enable them to support patients.

An induction programme included time to read the practice's policies and procedures. Newly employed staff were supported in the first few weeks of working in the practice. The mandatory training for all staff included safeguarding, health and safety, fire, dignity and respect

and CPR. However there was no evidence that staff had completed training in infection prevention and control and manual handling. The practice manager told us that they needed a structured approach to staff training to enable them to have training on a needs basis approach. The practice had timescales around refresher training and this was completed in line with national expectations. However, the practice did not have a record of all training undertaken and details of when refresher training would be required.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures	<p>Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers</p> <p>People who use the services were not protected against risks as the provider did not have effective recruitment procedures in place to ensure that staff relevant checks had been undertaken when employing staff.</p> <p>Regulation 21 (a) (i)</p> <p>People who use the service were not protected against risks as the provider did not have effective recruitment and selection procedures in place.</p> <p>Regulation 21 (b)</p>
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	