Care Quality Commission

Tieve Tara Medical Centre

Quality Report

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

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Summary of findings

Overall summary

Tieve Tara Medical Centre is located in Castleford. The practice has four GP partners. It is a teaching practice although there were no trainee doctors at the time of our inspection. The practice also has two practice nurses, a healthcare assistant, a practice manager and administrative staff. All the regulated activities the provider is registered to provide were inspected. These are diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder and injury.

There are 5236 patients registered at the practice. The practice is open from 8am until 6.30pm from Monday to Friday except on Wednesdays, when the practice is open until 7.45pm. One Wednesday a month the practice closes at 12 noon for staff training, but it reopens at 6.30pm for the extended hours' surgery.

During the inspection we spoke with 10 patients and looked at the Care Quality Commission (CQC) comments cards completed by 12 patients. The majority of patients told us that staff were helpful and respectful. Some of those we spoke with told us they had difficulty accessing appointments. We also spoke with two GPs, the practice manager, a practice nurse and five administrative staff.

The practice was accessible to patients with physical disabilities. All areas were visibly clean, hand washing facilities were available in each clinical room and all areas relating to the prevention and control of infection had been considered.

The practice provides a service for all population groups safely and effectively. Staff are caring and responsive to the needs of patients and they deliver care in line with best practice guidelines. The practice works with other health and social care organisations, with several other services being available within the practice to meet the needs of the population. It carries out an annual patient survey and changes are made following feedback from patients. The practice did have a patient participation group (PPG) but this is no longer active. They are currently encouraging patients to engage and be part of a new PPG.

All staff are aware of their role and there is an established management structure in place. The GPs have individual clinical responsibilities. Responsibility for areas such as finance and human resources has been delegated to the practice manager.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
Overall the services were safe. One of the GPs had the role of safeguarding lead and all staff were knowledgeable about how to report any concerns.

Emergency drugs and equipment were available and ready for use. There were some out of date controlled drugs secured in a safe awaiting disposal. All staff had been trained in dealing with emergencies. All areas of the practice were visibly clean and checks were carried out by the practice to ensure required standards of cleanliness and hygiene were met.

Are services effective?
The service was effective. There were systems in place which supported GPs and other clinical staff to improve outcomes for patients. The practice was a teaching practice and the GPs promoted a learning culture throughout. All staff had an annual appraisal to review performance and agree objectives for the following year. Training needs were identified and training was monitored.

The practice worked with other health and social care providers. A counselling service was provided and patients could also access substance and alcohol misuse therapists. The GPs had started a new initiative working with hospital consultants to educate patients on how to manage illness at home and prevent injuries.

Are services caring?
The service was caring. We looked at 12 CQC comment cards that patients had completed prior to the inspection and spoke with 10 patients on the day of the inspection. Patients were positive about the practice. They commented that the staff were friendly, helpful and caring.

Staff we spoke with told us that although conversations with patients could be overheard in the reception area, a private room was available for confidential conversations. GPs had a good understanding of consent and the Mental Capacity Act 2005, and an advocacy service was available to support patients when necessary.

Summary of findings

Are services responsive to people's needs?

Overall the service was responsive. The practice was accessible to people with disabilities. Staff were knowledgeable about interpreter services for patients where English was their second language. GPs provided services to meet the needs of the population. The practice was open until 7.45pm one night a week.

Patients were able to leave written comments in a box at reception. The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. We saw that written complaints were documented, but no record was kept of verbal complaints or feedback.

Are services well-led?

The service was well-led. The practice had a clear vision and set of values which were understood by staff.

The GPs had individual clinical responsibilities. Matters such as human resources and finance had been delegated to the practice manager.

All significant events were analysed and discussed in practice meetings with a view to improvements being made where possible.

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 worked with other services to support patients. Some of these were available in the same building.

There was a lead GP for safeguarding vulnerable adults. All staff had received appropriate training and there was an up-to-date policy in place to provide guidance.

The practice monitored the take-up of vaccinations such as influenza and shingles, and contacted eligible patients who had not had their vaccinations. Home visits could be arranged.

People with long-term conditions

The practice nurses had a system to ensure all patients with long-term conditions were invited for regular health checks. All long-term conditions were assessed at the same time to avoid multiple attendances.

Information about long-term conditions was available on the practice's website. Health promotion information was also available in the waiting area of the practice.

Mothers, babies, children and young people

Staff were knowledgeable about child protection and a GP took the lead for safeguarding. All staff had received safeguarding children training.

Vaccination clinics were held for babies and older children. Urgent 'on the day' appointments were available for babies and young children. Ante-natal clinics took place at the practice weekly. The practice's website included information relating to family health, women's health and sexual health.

The working-age population and those recently retired

Patients were able to request a telephone appointment with a GP or practice nurse. Once a week GP appointments were available until 7.45pm. Patients were given information about how to access medical help when the practice was closed. The GP out of hours' service was accessed via the NHS 111 service.

People in vulnerable circumstances who may have poor access to primary care

Staff were knowledgeable about safeguarding vulnerable adults. They had access to the practice's policy and procedures and had received training appropriate to their role.

Summary of findings

Interpreter services were available for those who did not speak English as a first language. A GP was the lead for patients with learning disabilities, and a weekly surgery was held for these patients.

People experiencing poor mental health
Information about mental health and support organisations was available on the practice's website. Counselling services were available at the practice. GPs had knowledge of the Mental Capacity Act 2005, independent advocacy services and Deprivation of Liberty Safeguards (DoLS).

Summary of findings

What people who use the service say

We received 12 completed CQC comment cards and spoke with 10 patients on the day of our inspection.

The patients who completed comments cards all made positive comments about the practice. They told us they thought the staff were friendly and caring, and patients gave examples of when GPs had been particularly supportive. One patient commented that appointments could be difficult to get, but another commented that they were always seen when needed, even if all the appointments were booked up.

The comments made by the patients we spoke with varied. Some told us that it was difficult to get through to the practice by telephone, and the appointments were usually booked up by the time they got through. Others told us they were always able to pre-book appointments, and were always seen if it was an emergency. Most patients told us they were given enough time during their appointments and the GPs and practice nurses listened to them.

The patient survey carried out by the practice in 2013 showed that 80% of patients who responded found it very easy or easy to access an urgent on the day appointment with a GP when requested. Almost three quarters of patients said it was very easy or easy to book a routine appointment with a GP. The survey showed that 92% of patients rated the quality of care they received as excellent or good, and 96% said they would definitely or probably recommend the surgery to someone moving into the area.

The results of the latest national GP patient survey were published in July 2014. These showed that 92% of patients at the practice said the last GP they saw or spoke to was good at giving them enough time, and 94% had confidence and trust in the last GP they saw or spoke to. These responses were better than the Clinical Commissioning Group (CCG) average. However, on some of the questions concerning access to GP services, the practice was not rated as well as others in the CCG area. Only 61% found it easy to get through to the surgery by phone and only 43% of patients reported that they usually saw their preferred GP.

Areas for improvement

Action the service SHOULD take to improve

Although clinical audits were being carried out available data, such as outliers, was not used to help plan and structure the audits more effectively.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

- One of the GPs carried out weekly visits to a large care home for people with neurological needs in the area. They built up a relationship with patients and proactively addressed their needs.
- There were 28 community homes in the area for people with learning disabilities. One of the GPs held a surgery one afternoon each week so patients at the homes could be seen at regular times and for the length of time they required.
- There was a new initiative at the practice where the GPs worked with paediatric and orthopaedic hospital consultants. The aim was to educate patients and their families in order to avoid minor injuries and manage short-term illnesses at home. This initiative had only recently started at the time of our inspection.

Care Quality Commission

Tieve Tara Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspector was accompanied by a GP, a Specialist Advisor and an Expert by Experience. Experts by Experience are people who have experience of using care services.

Background to Tieve Tara Medical Centre

Tieve Tara Medical Centre is located in Castleford. The practice has four GP partners. It is a teaching practice although there were no trainee doctors at the time of our inspection. The practice also has two practice nurses, a healthcare assistant, a practice manager and administrative staff. There are 5236 patients registered at the practice. The practice is open from 8am until 6.30pm from Monday to Friday except on Wednesdays, when the practice is open until 7.45pm. One Wednesday a month the practice closes at 12 noon for staff training, but it reopens at 6.30pm for the extended hours' surgery.

The practice is part of the Wakefield Clinical Commissioning Group (CCG). The practice serves a lower than average percentage of the population belonging to non-white minorities. The practice is located in a socio-economically deprived area in Wakefield. The practice has a young population. The percentage of people over the age of 65 is approximately 65% (lower than the average for England and the CCG area). The proportion of people in the practice area under 18 years old is approximately 26% and this is higher than the average for England and the CCG area.

Why we carried out this inspection

We inspected this GP practice as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

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:

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

Before our inspection we reviewed information we held and asked other organisations and key stakeholders to

Detailed findings

share what they knew about the service. We also reviewed some policies, procedures and other information the practice provided before the inspection. We carried out an announced inspection on 7 July 2014.

We reviewed all areas of the practice, including administration areas. During our inspection we spoke with a range of staff including two GPs, a practice nurse, the practice manager and administrative staff. We sought views from patients both face-to-face and via comment cards. We spoke with 10 patients who were using the service on the day of our inspection and reviewed 12 CQC comments cards.

Are services safe?

Our findings

Safe patient care

Procedures and processes were in place to report and record safety incidents and significant events, including allegations of abuse. The staff we spoke with were aware of their responsibilities in reporting incidents. We saw records of incidents and significant events. These provided evidence that reported significant events and adverse incidents were investigated and discussed with the GPs and other staff members. Positive comments, areas of concern and suggestions to prevent a reoccurrence were recorded along with the action that was to be taken. The staff we spoke with told us the whole practice met regularly and any significant events or incidents were discussed openly. We saw meeting minutes that documented staff being praised for reporting significant events and contributing to finding a solution to issues.

Safety alerts were initially dealt with by a member of the administration staff. They were then passed to a GP to take any action necessary. This was not a formal process and GPs took joint responsibility for making sure action was taken and information was disseminated appropriately.

Learning from incidents

We saw evidence that significant events and adverse incidents were shared with all staff at the practice and used as an opportunity to enhance the safety of patients and staff. We saw examples of incidents being appropriately investigated, with actions to be taken and learning points identified. The policy that was in place included how changes required following an adverse incident or significant event should be communicated to all staff. It also stated that appropriate training or education would be provided if required.

We saw minutes from meetings, which documented how issues were discussed openly with staff, who had the opportunity to contribute towards finding solutions. We saw an example of where the practice was unsure of current guidelines following the reporting of an incident. They contacted the appropriate body for advice then disseminated the correct guidance to staff.

Safeguarding

The practice had a safeguarding children and adults at risk policy in place. These documented the procedure to follow if staff had safeguarding concerns. We saw a flowchart to guide staff, and this was on display in the GP and practice nurses' consultation rooms.

There was a GP lead and deputy for safeguarding adults and children. All the staff we spoke with were aware of which GP was the lead and how they should report any issues. One staff member told us they had previously made a safeguarding referral and the lead had supported them throughout the process. We saw evidence that all staff had received training in the safeguarding of adults and children. Practice nurses had completed level 2 training and all the GPs had been trained to level 3. Training was updated every year. We were given an example of a recent safeguarding case being reported by a GP and this had been done appropriately and according to the policy.

The lead GP met with health visitors each week and any potential safeguarding issues were discussed. Any specific issues were documented in the safeguarding section of the patient's record. All GPs were able to access this if required.

Monitoring safety and responding to risk

All GPs took the lead for specific illnesses and other issues. These included mental health, cancer, learning disabilities, cardio-vascular disease and care homes. Clinical staff told us they worked well as a team and helped each other out when required.

All staff had been trained in cardiopulmonary resuscitation (CPR) in the previous year. The staff we spoke with confirmed that this was updated regularly and they knew where to find equipment to be used in an emergency.

There were procedures in place to assess, manage and monitor risks to patient and staff safety. These included checks and risk assessments of the building and environment. An external company had carried out a health and safety and fire safety audit during June 2014. The practice manager was monitoring an action plan to ensure improvements were made in a timely manner. We saw that staff were kept informed about the results of audits and improvements required during the frequent staff meetings.

The practice manager kept a record of the training all staff had completed and when it was due to be updated to ensure all staff had the right skills to carry out their work.

Are services safe?

Medicines management

There were clear systems in place for medicine management. When a patient requested a repeat prescription the prescription clerk always checked to see if all medication was required. The prescription clerk, practice manager and GPs worked together to reduce unnecessary prescribing. They had found that allowing patients to request repeat prescriptions by telephone was time-consuming, but patients appreciated this service and it led to GPs issuing repeat prescriptions for required medication only.

We checked the emergency drugs kept in the GP's bag. There was a good selection of appropriate drugs, and all were within the expiry date. Emergency drugs were also kept in a cupboard off the treatment room. These were appropriate and in-date. One of the practice nurses had the responsibility for checking drugs kept in the practice and ordering new supplies when their expiry date was approaching.

We saw the fridges were checked daily to ensure the temperature was within the required range for the safe use of the vaccines. One of the practice nurses carried out these checks and they were aware of the procedure to follow if the temperature went outside the required range.

The GP told us they did not use controlled drugs but there were some in the practice that needed to be disposed of. These were kept in a safe secured with a combination lock in a small room off the treatment room. The treatment room was secured by a keypad lock. We found 29 out of date ampoules of diamorphine in the safe, some dating back to 2007. The GPs and practice manager were aware of the regulations relating to the destruction of controlled drugs but had not pursued the disposal of these surplus drugs.

Cleanliness and infection control

During our inspection we looked at all areas of the practice, including the GP surgeries, treatment rooms, patients' toilets and waiting areas. All appeared visibly clean and were uncluttered. The patients who we asked told us they thought the practice was clean.

The practice had a contract with a cleaning company. We saw the cleaning schedule that was in place to state the frequency each area of the practice was to be cleaned. Cleaners signed the schedule to confirm they had carried out all the required tasks. The practice manager carried out regular checks on the quality of the cleaning. In addition we saw that the practice manager and cleaning contract manager carried out a monthly walk-around at the practice to ensure they were satisfied with the standard of cleaning. The cleaners attended the practice towards the end of each day. If they were required during the day, for example if a significant amount of mud had been walked into the practice, the company was contacted. The practice manager told us they were very responsive and attended quickly when requested.

We saw the infection prevention and control policy. This gave information about the clinical and non-clinical infection control leads, instructions for staff to follow and details of training required. We saw evidence that all staff had received training at the level required for their role. The staff we spoke with were aware of their responsibilities.

An external infection control nurse had carried out an infection prevention and control management audit in August 2013. The practice achieved a score of 93%. We saw that most of the improvements suggested had been made. A self-audit was due to be carried out by the practice in August 2014.

Instructions about hand hygiene were available throughout the practice and hand gels were in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment and consulting rooms. Couches were washable and there was vinyl flooring in treatment areas.

Staffing and recruitment

We saw that the practice had a policy in place to follow when they recruited new staff. This included guidance about seeking references and the carrying out of Disclosure and Barring Service (DBS) checks.

Only one new staff member had joined the practice in the previous five years. We looked at the personnel files of eight staff members, including the most recently recruited member, GPs, a practice nurse and reception staff. Although not all the required information, for example a full employment history, was available for staff who had worked at the practice for several years, it was available for the GPs and the most recently recruited member. We saw that all staff had provided evidence of their identity. This was kept locked in the safe with the DBS checks for all staff.

Are services safe?

An enhanced DBS check had been carried out for clinical staff. The practice manager also carried out checks to ensure the GPs and practice nurses were registered with the relevant professional body.

The practice manager worked with the GPs to ensure that there were sufficient staff on duty at all times. Staff told us that meetings were held for all staff at least monthly, with other meetings for staff groups in-between. They told us that they felt well supported to carry out their work and they were able to approach the practice manager or any of the GPs if they needed any advice. They told us that some training was carried out on-line but other training courses were carried out within the practice and involved the full staff team. We saw the practice manager kept a record of all training that had been carried out and they ensured this was updated when required.

We saw evidence that annual appraisal meetings were held for staff. The practice manager carried out the appraisals, and the GPs appraised the practice manager. Staff told us their performance during the year was discussed at these meetings and what was expected of them during the following year was also discussed.

Dealing with Emergencies

We saw that there were plans available to deal with emergencies that could disrupt the running of the practice. A detailed business continuity plan was in place and we saw it had been updated regularly. The plan covered loss of access to the building, non availability of utilities, such as electricity or water, incapacity of GPs and other staff and major incidents. The plan also included instructions for communicating with staff and patients in the event of an emergency.

The plan was available to all staff at the practice. It had also been shared with the Clinical Commissioning Group (CCG).

We saw that the practice had fire safety measures in place and the fire alarm systems were tested weekly. The practice manager monitored these.

Equipment

We saw that fire equipment checks, such as extinguishers and smoke alarms, were up to date. Maintenance contracts were in place to ensure that equipment was regularly tested and could be repaired when necessary.

Equipment was in place for use in an emergency. An automatic external defibrillator and oxygen were kept in the treatment room. These were checked weekly to make sure they were ready for use. All staff knew where they were kept. We looked at the emergency trolley. This contained appropriate equipment, although airways for children were not available. Other medical equipment, such as syringes and wound dressings, were kept in a locked cupboard. The practice nurse was responsible for checking all equipment was within its expiry date. We found a dressing with an expiry date of March 2013, and chlamydia testing kits that had expired in the previous month.

Electrical equipment had an annual portable appliance test (PAT). We saw that this was recorded and each piece of equipment had a sticker on it to confirm it had been tested in the previous year.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

The clinical staff we spoke with told us how they accessed best practice guidelines. We saw that all relevant guidance was available electronically. Weekly practice meetings were held where best practice was discussed. Also, every month the GPs and practice nurses met and updates such as those from the National Institute of Health and Care Excellence (NICE) were discussed. Meeting minutes provided evidence that issues such as new prescribing guidance were discussed and information disseminated.

We saw that the GPs each took lead responsibility for areas of work within the practice. These included epilepsy, palliative care, contraceptive services and dementia. The practice nurse told us they carried out health checks for patients with long term conditions, including diabetes and asthma. They explained the system in place to ensure patients were notified when a health check was due. They told us that some patients were reluctant to engage and attend health checks. In these cases they telephoned patients if they were worried about them.

The practice was a teaching practice and supported registrars training to be GPs. The GPs told us this led to a culture of training, and a GP debriefed the registrar after all their clinical sessions. We saw evidence from the General Medical Council (GMC) that trainees spoke positively about the training they received at the practice, with higher than the national average scores being given.

Management, monitoring and improving outcomes for people

We saw that practice nurses operated a system to improve outcomes for patients with long term conditions. If a patient had more than one long term condition they were given longer appointments where all their conditions were considered. They found that patients preferred this and looking at all their conditions together was beneficial. GPs also carried out annual health checks for some patients, for example patients with learning disabilities.

There was a recall system in place to ensure patients with long term conditions had regular check-ups. When a patient did not respond to a letter asking them to make an appointment the practice nurse or healthcare assistant followed this up. The practice nurse told us that sometimes patients had been seen elsewhere, such as during a hospital appointment, and there were some patients who did not want to engage. However, they spoke with patients they felt they needed to see and on occasions they visited patients who they were concerned about.

The practice looked at the needs of their patient population and focussed on providing the required services at a local level. We saw that some clinical audits were carried out. We also saw an audit on the prescribing of morphine that looked at the number of prescriptions, cost and patient outcomes. Although we saw evidence that the practice worked around the needs of the patients no data was kept on how well the needs were being met. There was no discussion with the Clinical Commissioning Group (CCG) about the General Practice Outcome Standards (GPOS) or other available data that would help the practice focus on which areas to audit.

Staffing

The practice had procedures in place to support staff in carrying out their work. There was an induction programme for new staff to follow and we saw evidence that the most recently recruited staff member had followed this. We saw that all the policies and procedures for the practice were available on-line and all staff had access to them.

All staff had a written job description. The administrative and nursing staff had an annual appraisal meeting with the practice manager. Their performance was discussed and what was expected of them in the following year was also discussed. Staff told us they found their appraisal meetings helpful and the practice manager had an open door policy where they could discuss any issues with them at any time. The GPs jointly appraised the practice manager.

The practice nurse told us that their continuing professional development (CPD) was monitored by the practice manager. They said they were able to ask GPs for advice when required. The practice manager told us staff had received training on 360° feedback and they planned to implement this into the next appraisals as a way to improve performance. One staff member told us they had been apprehensive about the concept of 360° feedback but the training had fully explained it and the practice was committed to staff working to their full potential.

We saw that all the GPs had been revalidated and all had annual appraisals. Two of the GPs were appraisers and so were familiar with all the requirements.

Are services effective?

(for example, treatment is effective)

The practice manager kept a record of the training completed by all staff. They were aware of when mandatory training was due to be updated and this was arranged in advance. Staff told us they felt they had all the training they required to carry out their work effectively. They also said they were able to request additional training if they felt it would be beneficial to their work.

Working with other services

One of the GPs had a diploma in palliative care. The practice operated the Gold Standards Framework and regular palliative care meetings were held. The Gold Standard Framework is a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis. We saw that the practice worked well with the local hospice and community teams, with some records being appropriately shared to support the continuity of care for patients.

We saw evidence that the practice worked with a community therapy team to support patients who required services such as occupational therapy and speech therapy. The services worked together to support patients who would otherwise require hospital admission.

There were systems in place for GPs to refer patients for hospital consultations. The NHS Choose and Book system was in place but a GP told us most patients chose to be seen locally due to transport issues. We saw that appointments with other health professionals were available in the practice's building. Patients could be referred to see a physiotherapist, substance misuse therapist, or alcohol misuse therapist on the premises. Access to healthy lifestyle advice and counselling services were also available on-site.

GPs worked with other services, for example care homes in the area. Weekly visits were carried out so that the health needs of patients could be regularly assessed and the most appropriate care and treatment given. There was a new initiative at the practice where the GPs worked with paediatric and orthopaedic hospital consultants. The aim was to educate patients and their families in order to avoid minor injuries and manage short-term illnesses at home. This had only recently started at the time of our inspection.

If a patient attended the out of hours' service or the A&E department the practice was notified the following working day. The practice manager told us these attendances were monitored. They said that due to the location of these services most patients preferred to access the GP practice when it was open. When a patient attended A&E or the out of hours service it tended to be appropriate and not due to difficulty accessing appointments.

Health, promotion and prevention

New patients wishing to register at the practice completed a registration form and a health questionnaire. They were then offered and encouraged to attend a new patient appointment with the healthcare assistant or practice nurse. During this appointment healthy living advice was offered if appropriate, information about on-going conditions was noted to make sure all tests and health checks were up to date, and medication was checked. An appointment with a GP was then arranged if it was felt necessary.

We saw that screening programmes, such as cervical screening, were in place at the practice. Vaccination programmes were also established. These were for childhood immunisations and also for the winter flu vaccine or shingles vaccine. The practice nurse told us these vaccinations were widely advertised and they monitored the take-up rates to ensure patients who would benefit from a vaccination had access to one.

If a GP or practice nurse identified that a patient would benefit from additional support, such as from a counsellor or healthy lifestyle advisor, this was arranged. Three of the patients we spoke with told us they had been offered and attended the practice for additional support. This included attending a smoking cessation support session and having bereavement counselling.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We looked at the results of the most recent patient survey, carried out by the practice in 2013. This showed that 98% of patients who responded said reception staff were 'very helpful' or 'helpful'. We spoke with 10 patients during our inspection. The majority told us they were treated with dignity and respect by staff at the practice. We saw evidence that all staff had received training in conflict resolution and the majority had received customer care training during the month prior to our inspection.

The most recent national GP Patient Survey results were published in July 2014. These showed that 88% of patients found the receptionists helpful, and 71% were satisfied with the level of privacy when speaking with a receptionist. Also, 92% of patients said they had enough time with the GP during their consultation and 87% said they felt the GP treated them with care and concern. Most of the patients we spoke with told us they were given enough time during their appointment. Eight of the nine patients we asked told us they felt they were listened to during their consultations.

We looked at 12 comment cards that patients had completed prior to the inspection. All the patients made positive comments about the practice, with most stating they found the staff friendly, helpful and caring.

The waiting room was separate from the reception desk. There was an electronic check-in facility so patients attending for an appointment did not need to interact with the receptionists. All the patients who we asked told us that other people in the reception area could overhear conversations at the reception desk. Most of them told us they were not aware there was a private room available if they wanted to speak with a receptionist confidentially. The staff we spoke with told us there was always a private room available that they would use if they thought more privacy was required. There was no notice to inform patients of this facility.

We saw there were sufficient consultation rooms and treatment rooms available for all patient appointments. Consultation and treatment rooms had curtains around the examination couches to maintain patients' privacy. Patients were offered a chaperone prior to intimate examinations or treatments being carried out. Most of the patients we spoke with confirmed this. They also told us they could request to see a GP of a particular gender although they may have to wait longer for an appointment if they did this. We spoke to a practice nurse who told us there was usually a nurse available to chaperone patients when required. At times reception staff were asked to chaperone patients. Although training had not been provided the staff we spoke with were knowledgeable about the role of the chaperone. They told us the GP always gave them instructions and explained these to the patient to put them at ease.

One patient told us that all the staff at the practice had been particularly caring following a bereavement. Two patients told us their GP had offered to refer them to a counselling service. One of those patients told us that although they declined this at the time the practice was very supportive when they later asked to be referred to the service.

Involvement in decisions and consent

We saw that all GPs had received training in the Mental Capacity Act 2005. The GPs we spoke with told us they had a better understanding of issues relating to the mental capacity of patients following the training. One GP had developed expertise in the area due to the work they carried out in a nearby care home for people with neurological needs. This work had also given them experience in the application of Deprivation of Liberty Safeguards (DoLS) regulations. These regulations are applied when restrictions or restraints are used to ensure the safety of the patient but the person lacks the capacity to make these decisions themselves. A Mental Capacity Act policy and guidance was available for all staff.

The GPs and practice nurse we spoke with had a good understanding of consent. They told us that most consent was given verbally but they were aware of when consent should be recorded and when a patient should sign to formally give their consent prior to a procedure being carried out. GPs were aware of independent advocacy services and how they could be accessed. If a patient had difficulty understanding their consultation or treatment, or had difficulty expressing their views, this service was used.

The majority of the patients we spoke with told us that GPs always explained things to them in a way they understood. They said that they were asked for their consent when this was appropriate. Most patients said they were given options and were involved in decisions about their care and treatment, but some said they did not feel involved.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had consultation rooms and waiting areas on the ground and first floors of the building. Access was via electronic doors and all rooms were accessible to wheelchair users. There was a passenger lift available. There was sufficient seating available in all public areas. The practice had a large car park, and street parking was also available.

The staff we spoke with told us very few patients did not speak English as their first language. They were all aware of how to access an interpreter service. They said they accessed the service approximately once a month. One of the GPs was able to speak several languages.

There was a large care home for people with neurological needs in the area. One of the GPs visited the home weekly in order to build up a relationship with patients and address their needs. This reduced the need for emergency visits. There were also 28 community homes in the area for people with learning disabilities. One of the GPs held a surgery one afternoon each week so patients at the homes could be seen at regular times and for the length of time they required.

Health visitors and district nurses had rooms in part of the building. A midwife visited the practice twice a week. A physiotherapist also visited the practice so patients did not have to travel to use the service. One of the patients we spoke with told us they appreciated being able to access most of the health services they needed in one building. We saw that a counselling service was provided from the practice. A substance misuse therapist visited the practice twice a week and an alcohol misuse therapist also held regular sessions for patients.

The Citizen's Advice Bureau (CAB) held sessions at the practice, providing advice and support to patients, for example with benefit claims. Healthy lifestyle advice and courses were available. We saw there was a weekly smoking cessation advice session at the practice. GPs participated in the Wakefield Council Get Active exercise referral scheme to encourage safe activity to improve patients' lives. The additional services arranged by the practice reflected the needs to the local population. The practice manager told us they had found patients were more likely to access these services when they were based in the practice.

Access to the service

We spoke with 10 patients during our inspection and their experience of making an appointment varied. Most patients told us it was difficult to contact the practice by telephone when the telephone lines opened each morning. Some told us that 'on the day' appointments had usually been booked up by the time their call was answered. Six of the patients we spoke with had pre-booked their appointment several days earlier. One patient told us they were usually offered an 'on the day' appointment if they did not need to see a specific GP, and another told us they had no difficulty if they wanted to book an appointment in advance.

The practice manager explained that appointments could be booked up to two weeks in advance. On the day of our inspection we saw that pre-bookable appointments were booked up for the following two days, but were available for three days later. Each day there were usually 16 pre-booked appointments and 40 bookable on the day. The practice manager said that patients could telephone for an urgent appointment from 8am each day. Some patients told us the line was engaged when they telephoned but the practice manager explained this was only prior to 8am when the out of hours' service took the calls. They said that from 8am calls were placed in a queue and each patient was told their position in the queue. We saw that a new telephone system had been put in place following concerns raised by patients about the cost of telephone calls. All calls were charged at the local rate.

When all the appointments for the day had been allocated patients had access to a triage system. As a minimum the practice nurse or on-call GP telephoned the patient. If they felt an 'on the day' appointment was necessary one was made. We saw evidence that on the day of our inspection several patients had been given an appointment that day after speaking with a GP. The practice manager told us that they thought the system worked; parents of young children knew they could be seen when required and this meant they were less inclined to attend A&E.

Some of the patients we spoke with told us that they were not offered a triage service, and if all the 'on the day'

appointments had been allocated they were told to telephone the following day. The practice manager told us it was their policy to offer the triage service for all patients who requested an urgent appointment.

The latest national GP survey results published in July 2014 showed that 61% of patients found it easy to get through to the practice by telephone. This was lower than the Clinical Commissioning Group (CCG) average of 72%. Over 80% of patients were able to get an appointment to see or speak with someone the last time they tried. The practice's 2013 patient satisfaction survey showed that 76% of patients found it very easy or easy to get through to the practice on the telephone.

We saw that telephone consultations could be booked by patients, and home visits could also be requested. Where a home visit was requested a GP telephoned the patient first to assess if this was necessary.

Patients who were unable to attend during normal opening hours could pre-book an appointment to be seen during extended opening hours. Every Wednesday appointments could be made up to 7.45pm which was particularly beneficial for patients who worked during the day.

Concerns and complaints

We saw that a complaints and comments procedure was in place. This procedure documented how complaints should be dealt with. A complaints and comments leaflet was also available in the waiting area of the practice. This provided information about how to make a complaint, and contained a form for patients to complete if they wished to do so.

We saw that there had been one formal complaint made in the 12 months prior to our inspection. A record of all correspondence had been kept, and we saw that the patient had been offered a meeting, which they had declined. We saw that the complaint had been discussed with the GPs. However, the complaint had not been resolved and the patient had been advised to contact the Parliamentary and Health Service Ombudsman (PHSO) if they were not satisfied.

The staff we spoke with told us that if they received a verbal complaint patients were asked if they would like a form to complete or if they would like to speak with the practice manager. The practice manager told us patients rarely wanted to take their complaint further. However, a record was not kept of verbal complaints made. The practice manager told us this was due to patients not providing enough information. They said most complaints were about the appointment system, and when the system was fully explained to patients they were satisfied. The complaints procedure stated that if a verbal complaint was made a written record of it would be given to the administration manager. This was not happening so there was no record of complaint themes.

Although most of the patients we asked told us they did not know what the formal complaints' procedure was, they told us they would speak with a receptionist, the practice manager or a GP if they had any concerns, and they would feel comfortable doing so.

There was a comments box in the reception area for patients to use. The practice manager told us no comments had been made for over six months.

Are services well-led?

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

Our findings

Leadership and culture

The GPs and practice manager told us changes had been made in the practice following the retirement of a GP at the end of 2013. It had been decided that a new GP would not be recruited until they could be sure the option was affordable and sustainable. The remaining GPs had started to work extra hours and locum GPs were used when necessary.

There was an established management structure in place and all staff were aware of who their line manager was and where they could go for advice. The staff we spoke with were aware of their role and had been given a job description and work objectives. Staff told us they worked well as a team.

We saw there was a practice charter and this was available in writing for patients. The charter gave information about patients' rights, responsibilities, the practice philosophy and how patients could expect to be treated. The staff we spoke with were aware of the charter and most of the patients we spoke with told us they were treated according to this information.

There was a schedule of meetings in place for the whole of 2014. These included clinical meetings, practice board meetings and 'target' meetings where the whole practice met. We saw that there were regular meetings with the Clinical Commissioning Group (CCG) where information could be shared.

Governance arrangements

One of the practice's GPs retired at the end of 2013. The remaining partners had decided not to recruit a replacement immediately. They told us that a decision would be made later in 2014 when they had more information about future funding for the practice. The remaining GPs were working extra hours and locum GPs were also employed when necessary. The practice was a training practice; registrars and medical students had placements at the practice. Registrars are qualified doctors undertaking post graduate general practice training.

Each GP had responsibilities for certain aspects of clinical care in the practice. They were all aware of their responsibilities and these were around their particular specialisms. Matters such as finance and human resources had been delegated to the practice manager.

The GPs told us they were considering joining a federation of four or five practices in the area that would work together. It was thought that this would help with the governance of the practice and would be a more efficient way of managing non-clinical aspects of the practice. It would also mean clinical expertise could be shared.

The practice submitted governance and performance data to the CCG. Regular meetings were held between clinicians and the CCG, including clinicians from other practices.

Systems to monitor and improve quality and improvement

We saw that information was collected for the Quality and Outcomes framework (QOF) and national programmes such as vaccination and screening to monitor patient quality outcomes. These areas were audited. We saw that the practice also carried out clinical and safety audits. However, the practice could make better use of outcome data to help plan and structure their audits more effectively.

Staff told us they had annual appraisals which included looking at their performance and development needs. Staff had received training in 360° feedback and the practice manager told us this would be used as part of the next round of appraisals.

The practice manager and GPs were involved in risk management and we saw all the required risk assessments had been carried out, with improvements being made or scheduled where required. Staff training was monitored. Quality monitoring was taking place around significant events and we saw that all staff were aware of how to report significant events and involved in discussing ways to improve

Patient experience and involvement

The practice did not have a patient participation group (PPG). PPGs are groups of patients who work together with the GPs to improve services and to promote health and improved quality of care. The practice manager explained that they had a group until approximately 18 months ago when the chair of the group moved out of the area. They told us that although the group met it was not representative of the patient population and although they tried various ways to improve representation new members did not join. When the chair moved out of the area none of the other members were willing to take on the role and members stopped attending meetings. We saw notices

displayed throughout the practice asking patients if they would be involved in the PPG. There was also information about how to join the PPG on the practice's website, although this stated that the group was still active. The practice manager told us they had asked the CCG patient involvement team for ideas about setting up a new group but they had difficulty engaging patients. The PPG carried out a patient survey in 2012.

We saw there was a comments box for patients to use in the reception area. The practice manager told us they rarely had any comments made. In addition to the national GP patient survey the practice carried out their own patient survey.

At the time of our inspection we saw copies of the survey in the waiting area and a notice asking patients to complete one. We saw that a similar survey had been completed during 2013. The practice manager told us very few patients voluntarily completed a survey so they sat with patients in the waiting area and offered help to those who requested it. They said very few surveys had been completed recently and they would do the same this year in order to collect patient feedback. Feedback from patients could also be provided on-line via a link from the website. However we heard this function was also not well-used. Although the practice was continuing in its efforts to engage with their patient base other proactive approaches to encourage patient feedback would be beneficial.

We saw evidence that the practice compared survey results with those of the previous year to see areas where improvements had been noticed or where patients felt the service had declined. We saw that in 2013 patients had expressed dissatisfaction with the cost of telephoning the service. As a result of this the system had been changed so calls were charged at local rates.

Staff engagement and involvement

We saw that regular practice meetings were held with all staff members. Staff said the minutes were available for them to see if they had been unable to attend meetings. Positive feedback and areas for improvement were shared with staff. Staff told us they were able to freely express their views at work and the practice manager had an open door policy.

Staff told us there was a culture of openness at the practice, and a whistleblowing policy was in place if it was needed. Whistleblowing is a process for a worker to report suspected wrong-doing at work.

Learning and improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Staff were able to suggest training courses that would be helpful to them, and all training was monitored by the practice manager to ensure it was up to date. The practice had half a day protected learning time each month where the staff could get together in a group setting. Other external training or on-line training was also arranged.

Newly employed staff had a period of induction to support them. The administrative staff, practice nurses and healthcare assistant had annual appraisal meetings with the practice manager. The practice manager monitored the continuing professional development (CPD) of the practice nurses and GPs told us that they would be involved in the appraisals for the practice nurses from the next meetings. The GPs also had annual appraisals, and they in turn appraised the practice manager. The GPs we spoke with told us of the culture of openness. They said they would alert each other if they had concerns about consultations.

Identification and management of risk

The practice had systems to identify, assess and manage risks related to the service. There was a health and safety policy in place to give clear guidance to staff. We saw a health and safety risk assessment and audit had also been carried out for the practice.

All incidents, accidents and significant events were recorded and the staff we spoke with were aware of their responsibilities in this area. The recorded events were analysed and improvements were made where necessary. We saw that all significant events were discussed in practice meetings and feedback was given to staff.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice worked with other services, some based in the same building, to support patients to receive the care they required. For example the district nursing team regularly met with the GPs. The community teams based in the building were able to offer support at home to patients unable to travel to the practice.

The practice had a dementia lead GP and a safeguarding adults lead GP. There was an up to date policy for vulnerable adults and all staff had received training at the appropriate level. Training in the Mental Capacity Act 2005 had been carried out and staff were knowledgeable about the action to take if a patient had difficulty understanding their consultation.

When a patient had an appointment with the practice nurse their other conditions were also assessed. This meant the patient did not have to return for other check-ups. The take up rate for vaccinations such as for influenza or shingles was monitored. Eligible patients who had not attended for their vaccination were approached to be offered an appointment. Home visits could also be arranged.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice nurses managed patients with long term conditions, such as chronic obstructive pulmonary disorder (COPD), asthma and diabetes. They had a system in place to invite patients for regular health checks and assessments. The system had been changed so that if a patient had more than one long term condition they could all be assessed during the same appointment. Patients who did not make appointments for health checks were contacted to encourage attendance or to arrange a home visit when necessary.

Health promotion information was provided to patients with long term conditions during their appointments. We saw that information about conditions was available in the waiting area. Local support groups were also advertised in the waiting area.

Information about several long term conditions was available on the practice's website. This included fact sheets, tests and treatments, and information about other organisations that could give advice.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice had up to date child protection policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were easily available to staff on their computers. All the staff we spoke with knew who the lead GP for safeguarding children was, and they were all aware of their responsibilities. We saw evidence that all staff had received training to the appropriate level.

We saw the consent policy. This provided information about consent for children and young people and explained Gillick Competency.

There was a weekly clinic where childhood immunisations were carried out by the practice nurse. Vaccinations for older children, such as human papillomavirus types 16 and 18 and Meningitis C, were also carried out. Weekly ante-natal clinics were held at the practice.

We saw that urgent appointments were made available for babies and young children, even where the usual appointments had been booked up.

The practice website included information for family health, women's health, sexual health and for children of different ages.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice was open until 7.45pm once a week so that patients who worked during the day could access appointments. GPs were available on other days until 6pm and if necessary urgent 'on the day' appointments could be given until that time. Telephone consultations with GPs or a practice nurse could also be requested by patients.

There was information on the practice's website, in the waiting area and in the practice booklet about where medical help could be accessed when the practice was closed. A walk-in-centre in Wakefield was open 8am until 8pm seven days a week and no appointment was necessary. The GP out of hours' service was accessed by telephoning the NHS 111 service.

Information for all patient groups was available on the website.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice had an up to date vulnerable adults policy and all staff were aware of who the lead GP in this areas was and what their responsibilities were.

One GP took the lead on patients with a learning disability. They held a surgery once a week for patients with a learning disability and they told us of the advocacy service available when they were required.

We saw that there was an in-house service for patients who had alcohol problems or were substance misusers.

Counselling was also offered within the practice. In addition the Citizens Advice Bureau (CAB) held sessions at the practice where patients could discuss other issues and seek advice, for example regarding benefit claims.

We heard that there were very few homeless people or travellers in the area but advice could be obtained from the Clinical Commissioning Group (CCG) if it was required.

The majority of patients spoke English as their first language. Staff were aware of how to access an interpreter service when required. One of the doctors was also able to speak several languages.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

Mental health information was provided on the practice's website. Other organisations who could help patients were also listed. There was a depression questionnaire on the website that was used by GPs to monitor a patient's condition or response to treatment. It was also used to indicate to patients if they may be depressed.

Counselling services, including bereavement counselling, were available at the practice. We spoke with patients who told us they had been offered counselling. They told us that if they declined the offer initially they were able to request it at a later date.

One GP made weekly visits to a care home where patients with neurological disabilities lived. This had given them a greater expertise in the area, and they also had experience in Deprivation of Liberty Safeguards. GPs knew how to access independent advocacy services and they had all been trained on the Mental Capacity Act 2005.