Treeton 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.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Treeton Medical Centre on 16 June 2015. Overall the practice is rated as good.

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

Our key findings were as follows:

- The practice offered a responsive and flexible appointment system based on patient feedback. This included a walk-in clinic on a Monday morning, late night opening and a telephone triage system.
- The practice had an active Patient Participation Group (PPG) that promoted services offered by the practice and shared health information within the local community.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles, including safeguarding and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment.
- Information about services and how to complain was available and easy to understand. Complaints were addressed in a timely manner and the practice endeavoured to resolve complaints to a satisfactory conclusion.
- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- There was a clearly defined leadership structure and all staff felt supported by management. The practice actively sought feedback from staff and patients.
- Risks to patients were assessed and well managed.
- The practice had relevant and up to date policies and procedures in place and held regular governance meetings.

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

Importantly, the provider should:

Summary of findings

- Make changes in the reception and waiting area so that patients can be afforded privacy and confidentiality when speaking with practice/reception staff.
- Ensure that a paper copy of the Business Contingency Plan is available in the practice in the event of computer failure.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. There were enough staff to keep patients safe. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons from incidents were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. Staff were aware of their roles and responsibilities in regard to safeguarding and knew who to speak to in the event of any concerns. The premises were clean and there were infection prevention and control policies in place. Medicines were well managed, including emergency equipment and drugs. However, in one instance, we observed some medicines being kept in an unlocked cupboard. The treatment room where the medicines were being stored did not have a lock on the door.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. Staff had received training and support, appropriate to their roles and worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us they found staff caring and we heard from the doctors that the GPs took pride in knowing their patients well. Patients said they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment. Information to help patients understand the services being provided was available and easy to understand. We saw staff treated patients with kindness and respect. Telephone calls were handled in a private back office. We observed telephone contact with patients and this was well managed, courteous and respectful of confidentiality. The waiting area, however, was cramped and had a low ceiling. This meant patient conversations with reception staff were easily over heard, and this meant that it was difficult to maintain privacy and confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of its local population and has met regularly with the NHS England Area Team and Rotherham Clinical Commissioning Group (CCG) in order to discuss how services can be improved. Patients said they found it easy to make an appointment with a preferred GP and welcomed the appointment of a female GP. Information about how to complain was available both in the practice and on the website. Learning from complaints was shared with staff and acted upon to improve the patient experience. Some patient groups, for example those with diabetes and asthma, were sometimes reluctant to attend clinics. The practice had responded to this and in these cases would telephone these patients to encourage future attendance. The practice was accessible for disabled people.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a long term vision to expand services and provide additional clinics, which was dependent on securing new or expanded premises. There was a clear leadership structure and staff felt supported by management. The practice had a number of appropriate policies and procedures in place and held regular practice meetings. There were systems in place to monitor and improve quality and identify risk. Staff received an induction, regular performance reviews and attended staff meetings. The practice was receptive to feedback from patients and staff which it acted upon and intended to undertake a patient survey later in the year. There was an active patient participation group (PPG).The practice recognised that workforce planning was essential to maintain good services and had embarked on managing the transition into retirement for the existing practice manager by appointing a job share partner to ensure continuity.

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

Good

The practice is rated as good for the care of older people. The practice had achieved a higher than average uptake rate of seasonal flu vaccination for older people. All patients over 75 years of age had a named GP and were offered an annual health check. The practice was responsive to the needs of older people, offering home visits and longer appointments. A Shingles vaccination was also offered to those aged 70 and above and a Pneumococcol vaccination was also offered to those aged 65 and above. The practice worked closely with other health care professionals, such as the district nursing team and community matron, and made sure that older people and their carers had the right support and care at the right time. There was also good links with the nearby nursing home. The GP visited weekly providing consultations and monitoring of long-term conditions.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The practice shared responsibility for managing long term conditions between the clinical staff. Nurses in particular managed asthma and diabetes clinics. GPs regularly visited a local residential establishment for young adults with learning and physical disabilities as required and also visited a similar residence for adults with autism. There were structured annual reviews in place to check the health and medications needs of patients were being met. Longer appointments and home visits were available when needed. The practice followed the Gold Standard framework for end of life care and liaised regularly with palliative care nurses and hospice professionals.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There was good awareness of safeguarding procedures and children who were or may be at risk were discussed at weekly clinical meetings. The practice also reviewed patients who were 'looked after' by the Local Authority. This includes children who were being fostered or were particularly vulnerable. The practice provided sexual health support and contraception, maternity services and childhood immunisations. Appointments were available outside of school hours, and same day appointments were available for all under-fives and The premises were suitable for children and babies.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The practice had extended hours on a Monday evening and a walk-in clinic on a Monday morning. The practice promoted online services for booking appointments as well as repeat prescriptions. There was a range of health promotion and screening which reflected the needs for this age group. For example, smoking cessation and weight-loss programmes which included directing working age people to other agencies and support services. GPs were also mindful of the impact of social isolation on the newly retired and offered support and directed to services as required.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in circumstances that may make them vulnerable including those people with a learning disability. It carried out annual health checks and offered longer appointments for people with a learning disability. The GP and practice nurse did regular home visits to patients for medical consultations and health checks for people who may be vulnerable due to their circumstances.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health, including people with dementia. The practice offered annual health reviews, longer appointments and home visits as needed for all patients who had poor mental health or dementia. Referrals were made to memory clinics and newly diagnosed patients with a mental health condition were closely supported and followed up

Summary of findings

What people who use the service say

We spoke with four patients and two members of the patient participation group (PPG) on the day of our visit. These patients told us that appointments were not usually delayed and that they were listened to and found the GPs "very caring". Whilst patients described how their consultations with clinical staff were always private, all expressed some concern that the reception area was cramped and that they could be overheard when talking at reception. One patient described a complex complaint that had been dealt with in the previous year. We looked into this and the patient confirmed that the complaint had been resolved.

We received 11 CQC comment cards which patients had used to record their experience of the service they had received from the practice. Whilst one patient found the current appointment system inconvenient, the remaining comments described how they felt they were "always treated with respect and dignity", "the surgery is clean and comfortable" and that "the service they give is excellent, also staff are very helpful and friendly".

Additional patient comments also praised the caring nature of the clinical staff and the ease of obtaining an appointment or an urgent home visit. Several commented on the dated and cramped building with one person saying "they do remarkably well with space they have".

We looked at the National Patient Survey (January 2015), which had sent out 307 surveys. There were 121 responses (39% completion rate). The survey found that 72% of patients who responded, usually saw their preferred GP. This was higher than the local average (59%) and the national average (60%). The survey also found that 92% of respondents said the last GP they saw or spoke to was good at listening to them, which was also higher than the local and national average of 89%.

Areas where the practice was below average included :

- 'Getting through to the surgery by phone easily' where the practice scored 59% against a local average of 73% which also matched the national average of 73%.
- 'Did you find receptionists helpful?' was 74% against a local average of 87% which also matched the national average of 87%
- Was 'the last nurse they saw or spoke to was good at involving them in decisions about their care?' was 80% against a local average of 86% and a national average of 85%.

Treeton Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Treeton Medical Centre

The practice is situated in a semi-rural area of Rotherham with a patient list of 6106, which is increasing annually. It offers services under a Primary Medical Services (PMS) contract. It leases its current premises from NHS Property Services. The practice population experiences slightly higher levels of social deprivation than other areas of England with low levels of British Minority Ethnic (BME) groups.

The practice provides services to a 50 bed nursing home, a 28 bed centre for adults with a learning disability and autism, both of which are visited regularly by the practice. The practice also offers services to a local eight bed facility that cares for young adults with learning and physical disabilities.

The practice has two male GP partners and a part-time female salaried GP. There are two practice nurses, a healthcare assistant, two practice managers who job share, one medical secretary and six reception staff.

The practice offers a 'walk-in' surgery on a Monday morning and pre-bookable surgeries for routine and urgent appointments during the week, including an extended hours clinic on a Monday evening. Out-of-hours care is provided by the Care UK service.

Services offered include childhood immunisations, cervical screening (smear tests), well patient checks (which include blood pressure, cholesterol testing and lifestyle advice) and chronic disease management checks for conditions such as diabetes and asthma. The practice also undertakes reviews of patients with a learning disability and those over 75 years of age. Dementia assessments and alcohol screening are also offered.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

Please note when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to CQC at that time.

Detailed findings

How we carried out this inspection

Before visiting the practice we reviewed information we hold about the practice and asked other organisations, such as NHS England and Rotherham Clinical Commissioning Group (CCG) to share what they knew.

We carried out an announced inspection at Treeton Medical Centre on the 16 June 2015. During our visit we spoke with a range of staff including the GPs, practice nurse, reception staff and both practice managers.

We observed communication and interactions between reception staff and patients; both face to face and on the telephone within the reception and waiting areas. We reviewed 11 CQC comment cards where patients had shared their views and experiences of the practice. We also reviewed documents relating to the management of the practice.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included reported incidents, national patient safety alerts, clinical audits, comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses.

We reviewed safety records, incident reports and saw evidence in minutes of clinical meetings where these were discussed. This showed the practice had managed these consistently and could demonstrate a safe track record over the long term.

Learning and improvement from safety incidents

There were systems in place for how the practice managed safety alerts, significant events, incidents and accidents. The practice reported only three significant events over the past year. These had been discussed at the monthly practice meetings and the learning shared throughout the team. Staff we spoke with confirmed there was an open and transparent culture. They knew how to raise issues for discussion and were encouraged to do so.

The practice manager showed us the electronic reporting system the practice used to record, manage and monitor all clinical and non-clinical incidents. We looked at three records of reported incidents and saw they had been completed in a comprehensive and timely manner. They included learning points or completed improvement actions.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and adults whose circumstances may make them vulnerable. We looked at training records which showed all the staff had received relevant role specific training on safeguarding. The doctor with overall responsibility for safeguarding had completed enhanced training, as had another partner at the practice. All staff we spoke to were aware who had the lead responsibility for safeguarding and were aware of their responsibilities, knew how to share information, record safeguarding concerns and how to contact the relevant agencies in both working hours and out of normal hours. Safeguarding policies, procedures and the contact details of relevant agencies were available and easily accessible for all staff.

There was a system in place to highlight vulnerable patients on the practice's electronic record. The practice held regular monthly multidisciplinary meeting with other professionals, such as the health visitor and the community matron. We saw evidence that at these meetings concerns were discussed and appropriate information was shared about children and vulnerable patients registered at the practice. We were told GPs did attend child protection meetings when possible, but this was often difficult because of surgery commitments. A written report was always sent in cases when the GP could not attend.

There was a chaperone policy which was visible on the waiting room notice board and in consulting rooms. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. Staff who were asked to be a chaperone had received up to date training and could explain what their role and responsibility was. They had all received Disclosure and Barring Service (DBS) checks (which checks people against a list of those who are not suitable or fit to work with children or vulnerable adults).

Medicines management

We checked medicines stored in the treatment rooms and found that the majority were stored securely and only accessible to authorised staff. During the inspection we observed a treatment room did not have a lock on the door. Inside the room an unlocked cupboard contained medicines and instruments. Staff told us that there were plans to have a lock fitted to the treatment room door, and have confirmed that after the inspection the lock was installed.

We checked the refrigerators where vaccines were stored. Staff told us the procedure was to check the temperatures on a daily basis and record it. We saw evidence of daily records being kept which were dated, had the temperature recorded and had been signed by a member of staff. We were told vaccines were checked for expiry dates on a monthly basis and disposed of in line with the practice protocol. We looked at a selection of vaccines and found they were within their expiry date. Expired and unwanted medicines were disposed of in line with waste regulations.

Good

Are services safe?

There was a repeat prescribing protocol in place. Requests for repeat prescriptions were taken in person at the reception desk or online via the practice website. Telephone ordering was discouraged to minimise the risk of error. We observed several prescriptions being collected, and saw that appropriate identity checks were made. Additional checks were in place for controlled drugs and we were told patients were asked to sign for these prescriptions before being issued. All prescriptions were reviewed and signed by a GP before they were given to the patient.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice.

Cleanliness and infection control

We found the premises to be clean and tidy. We saw there were cleaning schedules and records of when cleaning took place. Patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness or infection control. The practice had a regular cleaner who attended each day during surgery hours. We saw evidence of good communication between the cleaner and practice manager and a well-managed process.

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

An infection prevention and control (IPC) policy and supporting procedures were available for staff to refer to, which enabled them to plan and put in place measures to control the risk of infection. Personal protective equipment (PPE) including disposable gloves and aprons were available for staff to use. Hand washing sinks with hand soap, antibacterial gel and hand towel dispensers were available in treatment rooms. Sharps bins were appropriately located and labelled. The practice had access to spillage kits and staff told us how they would respond to blood and body fluid spillages in accordance with current guidance. There was a nominated lead for IPC who could support staff regarding any infection control issues. There had been a recent incident where a patient had presented blood glucose monitoring equipment to a receptionist, which had resulted in an accidental sharps injury. Staff were able to describe how they had responded to this incident and had put in place steps to prevent this reoccurring.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw there was a schedule in place to ensure all equipment was tested and maintained regularly. All portable electrical equipment was routinely tested. The sample of equipment we inspected had up to date Portable Appliance Tests (PAT) stickers displaying the last testing date which was March 2015. We saw evidence of calibration of equipment where required, for example weighing scales and blood pressure measuring devices.

Staffing and recruitment

We saw evidence that appropriate staff recruitment checks had been undertaken prior to employment. These included; proof of identity, references from a former employer, qualifications, registration with the appropriate professional body and criminal record checks through the Disclosure and Barring Service (DBS).

Staff told us about the arrangements for planning and monitoring the number and mix of staff required by the practice to meet the needs of patients. There was an arrangement in place for clinical and non-clinical staff, to cover each other's annual leave and sickness. Locums (temporary GPs) were sometimes used, and we saw evidence they were properly checked and supported whilst working at the practice. We were told there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Staff with responsibility for managing these arrangements said they were a flexible team, willing to meet the needs of the practice.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included an annual check of the building and we saw evidence of the latest check and the action plan resulting from this. Staff told us they would also verbally inform the practice manager if they identified any issues or risks. An example of this was the use of liquid nitrogen used in minor procedures. The nursing staff had

Good

Are services safe?

identified through a risk assessment that wearing a visor would reduce the risk of potential injury whilst using liquid nitrogen and this had been adopted by staff. We were told any identified risks were discussed at GP partners' meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's hear in an emergency). Staff were able to tell us the location of this equipment and how to use it. We saw records that confirmed it was checked on a regular basis.

Emergency medicines were available in a secure area of the practice. Staff checked the medicines on a regular basis and we saw records that corroborated this. We checked the medicines at the time of inspection and found them all to be in date.

A business continuity plan was in place to deal with a range of emergencies which might impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Identified risks included power failure, adverse weather and access to the building. The document contained relevant contact details for staff to refer. We found staff knew how to access the plan on the computer system, but were unable to locate a paper copy. The practice manager should consider keeping a paper copy to hand in case of computer failure or the need to evacuate the building.

We saw evidence fire equipment had been tested throughout the building in June 2015 and saw that in April 2015 a full risk assessment of fire safety and procedures had been undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff we spoke with could clearly outline the reason for their approaches to treatment. They were familiar with best practice guidance. They accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw evidence that new guidelines were shared and discussed in practice meetings. The implications for the practice's performance and patients were also discussed and required actions agreed. We found from our discussions with the GPs and nursing staff they completed thorough assessments of patients' needs in line with NICE guidance and these were reviewed when appropriate.

We were told nurses used up to date computer templates to plan the care they gave to patients and we saw evidence that nursing staff had regular clinical updates. Examples of this included training for cervical cytology screening (smear tests) and heart failure management. We heard from staff and saw evidence that the practice as a whole had clinical training days throughout the year. GPs told us they read medical journals and were eager to learn of new ways of treating patients effectively.

The GPs had areas of special interest, which included; women's health, substance misuse prescribing and diabetes care. Overall, the GPs had extensive experience of general medicine and we heard from the clinical staff that this expertise was shared amongst the doctors and the nursing team.

We saw that the practice worked effectively with end of life, palliative care. There was evidence of good working relationships across the team and with colleagues such as Macmillan cancer nurses and the palliative care & hospice team. The staff told us they used the Gold Standards Framework to inform their approach to patients who were approaching the end of their life. They had a register of these patients which was reviewed on a monthly or as required basis.

Management, monitoring and improving outcomes for people

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

We saw evidence that hospital letters and test results were promptly shared with clinical staff and accurately placed on the patient record.

Information collected for the quality and outcomes framework (QOF) and performance against national screening programmes was used to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for managing these conditions more effectively. This practice had also identified its prescribing rates for antibiotics was higher than the national average. Measures had been put in place to reduce the levels of prescribing and although staff were confident the rates of prescribing had fallen, the final data was still being collated.

The practice had undertaken a number of clinical audits in order to review its effectiveness. These included whether a particular group of patients should be considered for a form of anticoagulation therapy (drugs that help prevent blood clots and strokes). Another audit reviewed when patients with gallstones should be referred and a third looked at how varicose veins were managed. The audits showed the practice was following NICE guidance effectively.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw staff were up to date with essential training courses, such as annual basic life support and safeguarding children and adults whose circumstances may make them vulnerable.

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

Good

Are services effective?

(for example, treatment is effective)

The practice nurse was expected to perform defined duties and was able to demonstrate they were trained to fulfil these duties. For example, cervical cytology (smear tests) and diabetes care. The practice nurse was registered with the Nursing and Midwifery Council (NMC). To maintain registration they had to complete regular training and update their skills. The nurse we spoke with confirmed their professional development was up to date and they had received training necessary for their role.

All staff told us they felt supported in their role and confident they could raise any issues with the practice manager or the GPs. Staff had received an annual appraisal in the last year, or had one scheduled for the near future. We saw evidence training needs had been identified and confirmed the practice was committed to supporting or providing relevant training.

Working with colleagues and other services

The practice worked with other service providers and held regular multidisciplinary meetings to monitor patients at risk, review patients' needs and manage complex cases. We saw minutes that identified other health professionals who attended these meetings, for example health visitors, district nursing staff and palliative care nurses.

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

We heard that the two practice managers held a weekly meeting to discuss any practice issues, share information and undertake informal learning. There was no written record of these meetings, however, the practice told us they would consider recording them on a formal basis in future.

Information sharing

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

Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from the hospital, to be saved in the system for future reference.

Electronic systems were in place for making referrals which, in consultation with the patients, could be done through the Choose and Book system. The Choose and Book system is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Consent to care and treatment

Clinical staff were able to tell us how they ensured patients were able to consent to treatment. Clinical staff showed understanding as to when consent might not be easily obtained and how they would explore ways of communicating with patients with a sensory impairment or a learning disability. We saw there was a process in place to access interpreting services for patients whose first language was not English. Staff had a good understanding of the Mental Capacity Act and how it influenced how they worked with patients. We also saw clinical staff understood how children and young people may make decisions and consent to treatment under the Gillick competency test (which is when a person under the age of 16 is able to consent to medical treatment without the permission or knowledge of their parents).

Health promotion and prevention

The practice offered a variety of health checks that were suitable for all the population groups. New patients were routinely offered checks of blood pressure and given lifestyle advice around smoking and weight loss. Some of these checks were undertaken by the health care assistant and others by the nursing team or GP. We saw evidence that all clinicians had received the appropriate training for their role. The practice had an electronic screen in the waiting area that gave up to date and informative advice on health promotion. We saw evidence in reception and on the website that provided many types of advice from travel immunisations to sexual health.

Patients over 75 had a named GP and were invited for an annual health check, as were other patients such those who had a learning disability. The practice had achieved higher than average uptake rates for smear tests with 88.9% of women having a test in the last 5 years against a national average of 81.89%. Childhood immunisation uptake rates were also good, being 98.4% against a national average of 94.4% for the most common vaccine at 12 months of age.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information form the National Patient Survey (January 2015), where from a survey of 307 questionnaires, 121 (39%) responses were received. The survey showed 83% of respondents rated their overall experience of the practice as good and 87% said the GP treated them with care and concern and were good at listening to them. This scores slightly higher than the national average of 85%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 11 completed and whilst one patient was unhappy with the current appointment system, the majority were very positive, with remarks such as "always treated with respect and dignity", "fantastic", "the doctors and nurses are great" and one patient said they have always been treated with "the best care and respect at every stage".

We also spoke with 4 patients on the day of our inspection who all told us they were satisfied with the care they received and staff treated them with dignity and respect. They told us the clinicians listened to them, explained treatments and involved them in decisions about their care.

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

Staff told us if they had any concerns or observed any instances of discriminatory behaviour, or where a patient's privacy and dignity was not being respected they would raise these concerns with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

We observed reception staff were courteous, spoke respectfully to patients and were careful to follow the practice's confidentiality policy whilst talking on the telephone. We observed, however, that conversations between patients and staff in the reception area were easily overheard and the practice should take steps to improve this arrangement if possible. There was a discreet sign on display inviting patients to say if they needed a private conversation, but patients commented to us that "they had to whisper" which they found stressful.

Care planning and involvement in decisions about care and treatment

Both the patient survey information we reviewed and patients we spoke with on the day, rated the practice as good for involving them in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 81% of respondents said the GP involved them in care decisions, which matched the national average and was slightly lower than the local average of 83%. During their consultations with a nurse, 92% of respondents said that they felt they had enough time, which was the same as the local and national average score.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with on the day of our inspection and the CQC comment cards we received highlighted staff were caring, compassionate and provided support when needed.

This was also evident to us in discussion with clinical and non-clinical staff who described how they had worked with many of the same patients over many years and had come to know them and their families well.

Notices in the patient waiting area and on the practice website provided information on how to access a number of support groups and organisations. Written information was available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice told us they regularly liaised with Rotherham Clinical Commissioning Group (CCG) and other agencies to discuss the needs of patients and service improvements.

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

Longer appointments were offered to patients with complex needs. Examples of this were patients who had a learning disability, or a sensory impairment. We saw evidence that interpreters had been used to assist patients whose first language was not English. GPs and nurses were regularly able to visit patients in their own homes if that best met their needs. An example of this was the weekly visit to the local care home and also regular visits to residential services for people with a learning or physical disability or autism.

From a clinical perspective, the practice recognised it had been prescribing benzodiazepines (drugs that sedate and reduce anxiety) at a significantly higher rate than local and national levels. It responded to this by addressing the issues behind this figure, directing patients to other support services and reducing its prescribing rate gradually over time. Whilst it had achieved a much reduced prescribing rate, these figures have fluctuated. The practice had, however, seized upon the momentum achieved by the significant reduction overall and has continued to work across the team to maintain this improvement.

Tackling inequity and promoting equality

The practice had recognised the needs of the different population groups in the planning of its services. There were systems in place which alerted staff to patients with specific needs. Wheelchair access to the practice was not ideal, as this had to take place through a rear door, due to constraints caused by the lay out of the building. Staff offered assurance this was managed discreetly and were mindful it could be seen as being disempowering for a patient. The practice recognised the current limitations of the building and had tried to accommodate those with mobility needs as sensitively as possible.

Accessible toilet facilities were available for all patients and included baby changing facilities.

Interpreting and signing services could also be arranged and were used as necessary.

Access to the service

The practice offered patients two opportunities each day to make a same day urgent appointment; 8am for morning surgery and 2pm for afternoon surgery. In June 2015, in response to patient feedback, the practice introduced a walk-in service on a Monday morning. This ensured that any patient who arrived at the surgery by 10.15am would be seen by a GP in order of arrival. An extended hours

clinic was also available on a Monday evening between 6.30pm - 8pm.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey. This indicated patients were generally satisfied with the appointments system at the practice (this data was taken before the introduction of the walk-in clinic). For example, 72% of respondents described their experience of making an appointment as good against local and national scores of 73%. Seventy four percent of respondents found receptionists at the practice were helpful, which was lower than the local and national average of 87%.

Listening and learning from concerns and complaints

The practice actively promoted access to the complaints process on its website and in the practice reception. The practice manager took responsibility for managing the process, and responded to the majority of concerns, whilst a GP answered a complaint about a clinical matter. The small number of complaints received into the practice (four were recorded from the previous year) were appropriately handled and the learning shared amongst the team and acted upon. An example of this was when a patient complained that a member of the reception staff had communicated poorly. As a result, the reception and administrative staff attended customer service training to improve their skills in assisting patients.

We saw information was available to help patients understand the complaints system both in the reception area, in the practice leaflet and on the website. We saw that a form was available in reception for staff to record the details of any verbal complaints received into the practice,

Good

Are services responsive to people's needs?

(for example, to feedback?)

although this was a recent development and none had yet been recorded. Patients we spoke with were aware of their right to complain, but were generally unfamiliar with the process. All said they would be confident about making a complaint should the need arise. One patient had made a complaint in the past and felt that it had been satisfactorily resolved.

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 maintained a clear vision to deliver good quality care, and recognised that the current building and its limited capacity impacted on their ability to expand services and increase the number of patients on the practice list. Local building developments, including the creation of a 3,500 property housing estate and the proposal of a new health centre in the locality had led to discussions as to how the practice could be best developed. Discussions were being held with the local CCG as to how best assure the well-being of patients at the practice and provide the established and committed clinical and non-clinical team with the opportunity to develop their surgery.

Core values of continuous improvement in patient outcomes and listening to patient feedback were evidenced in the reduction of prescribing rates of benzodiazepines, antibiotics and the introduction of a walk-in clinic once a week.

Staff felt valued and supported and told us they enjoyed their work and were encouraged in their personal development.

Governance arrangements

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with or above national standards and had achieved 89 % of QOF points. We saw QOF data was regularly discussed at practice meetings in order to improve services. An example of this was in the active follow-up of diabetic patients who were reluctant to attend for screening and review of their treatment plan.

The practice had an ongoing programme of clinical audits which were used to monitor quality and to identify where any action should be taken. The GPs' clinical audits were often linked to medicines management or as a result of information from incidents.

The practice had arrangements to identify, record and manage risk. Risk assessments had been carried out, where risks were identified action plans had been produced and implemented.

We found there was an established management structure with clear allocation of responsibilities. The staff we spoke with all understood their roles and responsibilities and knew who to go to in the practice with any concerns.

Leadership, openness and transparency

Staff told us there was an open culture within the practice and all members of the management team were approachable, supportive and appreciative of their work. Systems were in place to encourage staff to raise concerns.

The practice manager and GPs had a weekly meeting and staff meetings were monthly. We looked at the minutes from meetings and found that performance, quality and risks were discussed. Staff told us they were happy to raise any issues and felt their opinions were listened to and valued.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. The practice sought the views of patients through the Patient Participation Group (PPG) and the NHS friends and family test.

The PPG was active with five regular members, four were older adults/recently retired and one was of working age.

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

Management lead through learning and improvement

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

Are services well-led?

Good

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

The practice had completed reviews of significant events and other incidents and shared the information at staff meetings to ensure the practice improved outcomes for patients. We saw evidence of this in minutes of meetings and logs of events.