Greenhill Health 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 Greenhill Health Centre on 19 May 2015. Overall the practice is rated as good.

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

Our key findings were as follows:

- Patients said they found it easy to make an appointment with a preferred GP, there was continuity of care and urgent appointments were available the same day.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles 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.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients.
- Risks to patients were assessed and well managed.

The practice had a number of policies and procedures in place and held regular governance meetings.

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 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. There were effective processes in place for safe medicines management.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed systems were in place to ensure all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm these guidelines were positively influencing and improving practice and outcomes for patients. Data showed the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group. The practice used innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others for several aspects of their care. Patients said they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment. Care planning templates were available for staff to use during consultations with patients. Information to help patients understand the services was available and easy to understand. We saw staff treated patients with kindness, respect and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Local Area Team and Sheffield Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a preferred GP, there was continuity of care and urgent appointments were available the same day. The practice had good

Summary of findings

facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available both in the practice and on the website. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a vision and strategy and staff were clear about their roles and responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures in place and held regular practice meetings. There were systems in place to monitor and improve quality and identify risk. Staff received induction, regular performance reviews and attended staff meetings. The practice proactively sought feedback from patients and staff which it acted upon. There was no patient participation group (PPG).

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. Nationally reported data showed outcomes for patients were good for conditions commonly found in 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. The practice worked closely with other health care professionals, such as the district nursing team and community matron, to ensure housebound patients received the care they needed.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The practice had a GP/practice nurse shared care approach to long term conditions. 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. Staff worked with relevant health and social care professionals to deliver a multidisciplinary package of care. For example, a diabetic nurse attends the practice once a month and holds a clinic.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of accident and emergency attendances. The practice provided sexual health support and contraception, maternity services and childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice told us all young children were prioritised and young children were seen on the same day if the parents thought it was necessary.

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, including pre-bookable early morning

Summary of findings

appointments. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group. For example, they offer chlamydia screening for younger patients.

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 vulnerable circumstances including those with a learning disability. It had carried out annual health checks and offered longer appointments for people with a learning disability.

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.

Summary of findings

What people who use the service say

We received 31 CQC patient comment cards which patients had used to record their experience of the service they received from the practice. We spoke with four patients on the day of our visit. All the patient comment cards were positive about the care provided by the GP, the practice nurse and reception staff with many comments conveying the excellent service they received by the practice overall. They all reported the doctor and practice nurse were competent and knowledgeable about their health needs. One person mentioned they waited to book an appointment and another was not happy with a consultation by a locum due to the medication they received.

We looked at the National Patient Survey (January 2015), which had sent out 292 surveys and received 113 responses (39%) completion rate). This showed 71% of people would recommend this practice to others and 68% were happy with the opening hours. These were below the local CCG and national averages.

Greenhill Health 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 and a practice manager specialist advisor.

Background to Greenhill Health Centre

Greenhill Health Centre is located in Sheffield in an area of high deprivation. The practice has off road parking facilities and disabled access.

The practice is registered with the CQC to provide primary care services. The practice provides services for 1800 patients under the Personal Medical Services (PMS) contract with NHS England in the Sheffield Clinical Commissioning Group (CCG) area. The PMS contract is a contract between a general practice and NHS England for delivering primary care services to local communities.

Over two-thirds of the patients had a long standing health condition and this considerably higher than the proportion of these kinds patients being seen in other practices.

The practice has a female GP, a nurse practitioner and a health care assistant. They are supported by a practice manager and four administration and reception staff.

The practice is open at Greenhill Health Centre from 8.00am to 6.00pm Monday, Tuesday Wednesday and Friday and 8.00 am to midday on Thursday. Outside of these hours urgent treatment and advice is provided by the GP out of hours service.

The practice treats patients of all ages and provides a range of medical services. Out of hours care is provided by the Sheffield GP collaborative service.

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 registered 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.

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 Sheffield Clinical Commissioning Group (CCG) to share what they knew.

We carried out an announced inspection at Greenhill Health Centre on the 19 May 2015. During our visit we spoke with a range of staff including the GP, practice nurse, practice manager and two members of the administration team.

Detailed findings

We observed communication and interactions between staff and patients; both face to face and on the telephone within the reception area. We reviewed 31 CQC patient 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. Significant events were discussed with the staff as and when they occurred, although there was no formal record. We discussed this with the practice manager and due to having so few staff and small premises it was easy to speak with staff during the day. 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 10 records of reported incidents and saw they had been completed in a comprehensive and timely manner. They included learning points or improvement actions.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all the staff had received relevant role specific training on safeguarding. Staff we spoke with 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.

The practice had a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained to level three in safeguarding and could demonstrate they had the necessary skills to enable them to fulfil this role. All staff we spoke with were aware of who the lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system in place to highlight vulnerable patients on the practice's electronic record. The practice held multidisciplinary meetings with other professionals, such as the health visitor, to discuss concerns and share information about children and vulnerable patients registered at the practice.

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. All staff who acted in the capacity of chaperone had received up to date chaperone training and could explain what their roles and responsibilities were. They had all received Disclosure and Barring Service (DBS) checks. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Medicines management

We checked medicines stored in the treatment rooms and found they were stored securely and only accessible to authorised staff. We checked the refrigerators where vaccines were stored. Staff told us the procedure was to check the temperatures daily. We were told vaccines were checked for expiry dates monthly. 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.

There was a repeat prescribing protocol in place. Requests for repeat prescriptions were taken in person at the reception desk, over the telephone, by post or online via the dedicated email address. We were informed about checks which were made to ensure the correct patient was given the correct prescription. All prescriptions were reviewed and signed by a GP before they were issued to the patient. The practice held regular meetings with the community pharmacist and were the most effective prescribing practice in the CCG area for 2014.

Good

Are services safe?

The practice had a good relationship with residents who lived nearby. They had raised concerns to the practice about the amount of diazepam which was being sold on the streets. The effective prescribing programme introduced by the practice ensured only those patients that needed the medicine were prescribed it. Feedback from local residents was the amount of diazepam sold on the streets had reduced. 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 in place and records were kept. Patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness or infection control.

There was a protocol 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 13 May 2015.

The practice audited their infection prevention control (IPC) by an external company. The audit dated May 2015 showed they were 90% compliant, we saw evidence of this. There were IPC supporting procedures available for staff to refer to, which enabled them to plan and implement measures to control infection. Personal protective equipment (PPE) which included 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.

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. We saw evidence of calibration of equipment where required, for example weighing scales and blood pressure measuring devices.

Staffing and recruitment

We saw evidence recruitment checks had been undertaken prior to their employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal record checks through the DBS.

Staff told us about the arrangements for how they planned and monitored the number and mix of staff required by the practice to meet the needs of patients. There was an arrangement in place for members of staff, which included clinical and non-clinical, to cover each other's annual leave and sickness. They told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice did use locums to cover for the GP and the practice nurse.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual checks of the building by an external company, the environment and dealing with emergencies. Staff told us they would also verbally inform the practice manager if they identified any issues or risks. These were then dealt with in a timely manner. Each risk was assessed, rated and mitigating actions taken to reduce and manage risk. We were told any identified risks were discussed with all staff.

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, this included access to oxygen and an automated external defibrillator (used to attempt to restart a person's hear in an emergency). Staff told us they knew the location of this equipment and how to use it. We saw records which confirmed it was checked on a daily basis.

Good

Are services safe?

Emergency medicines were available in a secure area of the practice. Staff checked the medicines monthly. 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 may 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.

There was a fire risk assessment in place and staff had all received fire training. There was information displayed in the practice on what to do in case of fire.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff we spoke with could clearly outline the rationale 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 were told clinicians held ad hoc meetings with staff where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. We found from our discussions with the GP and nursing staff they completed thorough assessments of patients' needs in line with NICE guidance and these were reviewed when appropriate. The GP and the health care assistant conducted regular home visits for those who required them to assess their patients. We saw evidence the practice had a 100% Quality Outcomes Framework (QOF) indicator for those patients with a bone fracture needing a bone spiral agent. The national average was 81%. (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 the implementation of preventative measures). We also saw the practice had a 100% QOF indicator for patients who presented with arterial fibrillation who received the correct therapy. This was in comparison to the national average of 98%.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 99% of the total QOF target in 2014, which was above the national average of 94%. Examples included: the performance for diabetes related indicators were better than the national average. The percentage of patients with hypertension having regular blood pressure tests was similar to the national average. The dementia diagnosis rate was comparable to the national average

We were informed the GP had a lead in specialist clinical areas such as diabetes and worked closely with the practice nurse. As a result of this they produced an excellent diabetes result in the QOF of 98.6% of possible points on offer.

The health care assistant performed home visits to do a pre-screening mental health assessments for those who experienced poor mental health or dementia. They also followed up requests from hospitals, and took blood tests where they were required. The GP also performed mini mental health assessments and used the dementia toolkit. Patients could then be offered advice or referred to other services for example the diabetic nurse, the district nurse who was based in the same building as the practice, or be referred to the Improving Access to Psychological Therapies (IAPT) councillor.

Clinical staff we spoke with were open about how they asked for and provided colleagues with advice and support. The GP told us this supported all staff to continually review and discuss new best practice guidelines. This was very much evident in the way the GP worked with the practice nurse and vice versa, as they could go and see each other if there was a concern about a patient. Effectively meaning this was a one stop shop if a patient presented with a condition that required them to be seen by both the GP and practice nurse at the same appointment. This was particularly useful for the working population group of patients.

The practice had registers for patients with long term conditions, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD).

The practice had a register of patients who required palliative care. Regular meetings to discuss these patients' care needs were held with other appropriate professionals, such as members of the district nursing team and palliative care nurses.

Discrimination was avoided when making care and treatment decisions. Interviews with the practice nurse and GP showed the culture in the practice was patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate

The practice nurse and GP showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to the national average. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the

Good

Are services effective?

(for example, treatment is effective)

process the practice used to review patients recently discharged from hospital. These patients had a named GP who looked at the discharge letters. Patients were reviewed by the GP or practice nurse according to their needs.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. The practice nurse and GP we spoke with used national standards for referrals. We saw evidence where regular reviews of elective and urgent referrals were made, and improvements to practice were shared with all clinical staff.

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 for scheduled clinical reviews, how they managed 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.

Information collected for the quality and outcomes framework (QOF) and performance against national screening programmes was used to monitor outcomes for patients. We saw evidence the practice had attained a QOF of 94% for those women aged 25 or over and under 65 who had a cervical screening test in the preceding five years, while the national average was 82%.

Clinical audit, clinical supervision and staff meetings were used to assess performance. The practice had an effective system in place for how they completed clinical audit cycles.

We saw evidence of five clinical audits carried out over the past two years. These showed a major reduction in the use of benzodiazepam, cephalosporin, diclofenac, quinolones and hypnotic medicines. In some instances these had been reduced from 205 patients to 61 patients now on repeat prescriptions. While others had been reduced to zero patients on repeat prescriptions. Those on repeat prescriptions had had their dosages lowered especially those who were in vulnerable circumstances. There was now no 10 milligram tablets of benzodiazepam prescribed and only 5 milligrams and 2 milligrams tablets prescribed. All staff were aware of the' at risk drug users' in the community. As a result of these audits the drug use quarterly cost had been reduced by over £35,000 over two years and this is the best performing practice in the CCG on medication usage. This was due to the major reduction in the prescribing of hypnotic, anxiolytics and lipid lowering drugs.

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 adults and children.

The GP was up to date with their continuing professional development requirements and had been revalidated 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.

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 and contraception advice. 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 practice nurse we spoke with confirmed their professional development was up to date and they had received training necessary for their role.

The health care assistant was appraised and supervised by the GP and worked closely with the GP.

All staff told us they felt supported in their role and confident they could raise any issues with the practice manager or the GPs. They had annual appraisals where any training needs were identified and confirmed the practice was proactive in 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 which identified other health professionals who attended these meetings, for example health visitors, district nursing staff and palliative care nurses.

Good

Are services effective?

(for example, treatment is effective)

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 they processed discharge letters and test results.

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.

We saw evidence where appropriate information was shared with other services and professionals to meet patients' needs. Shared access of specific information was available to the health visiting team, particularly around safeguarding children. We saw evidence the practice reported their concerns to the relevant authorities in line with the safeguarding policy

Consent to care and treatment

We found the GP was aware of the Mental Capacity Act 2005 and Children Acts 1989 and 2004 and their duties with respect to these. Staff we spoke with understood the key parts of the legislation and how they implemented it in practice. Staff told us what they would do in a situation if someone was unable to give consent, this included how they escalated it for further advice where necessary.

Clinical staff we spoke with demonstrated and understood Gillick competency and Fraser guidelines. These guidelines are used to assess whether a child under 16 has the maturity and understanding to make their own decisions and give consent to treatments being proposed. We were given an example of a patient being prescribed contraceptive pills.

Health promotion and prevention

The practice supported patients to manage their health and well-being and offered NHS health checks to all its patients over 40. They offered a full range of immunisations for children, flu vaccinations and travel vaccinations in line with current national guidance. We saw evidence those eligible for child vaccinations were generally in line with CCG percentages. Although in some instances those who received the vaccinations were higher than the CCG average for example 100% had received the meningitis C booster.

The practice identified patients who needed ongoing support with their health. They kept up to date registers for patients who had a long term condition, such as diabetes or asthma, which were used to arrange annual health reviews. Registers and annual health checks were also available for vulnerable patients, such as those with a learning disability, and the over 75s. They also identified other 'at risk' groups for example those patients who received end of life care. These groups were offered further support in line with their needs.

Healthy lifestyle information was available to patients via leaflets and posters in the waiting room and also accessible through the practice website. This included smoking cessation, weight management and travel health. Patients were signposted to other services as the need arose.

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 292 questionnaires, 103 (37%) responses were received. The survey showed 82% of respondents rated their overall experience of the practice as good and 85% said the GP treated them with care and concern and were good at listening to them. These figures were in line with national and local CCG averages.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 31 completed cards which were all positive about the service they experienced. One person commented on the supportive service provided to them at the time of bereavement.

We also spoke with four 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 which took 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. We observed conversations between patients and staff in the reception area were not easily overheard, but this had been a problem in the past which had been rectified. Staff told us if patients required private conversations they would take to them any room that was free.

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 71% of respondents said the GP involved them in care decisions and patients felt they had enough time to make an informed decision about the choice of treatment they wished to receive.

All staff said they knew their patients and did not have anyone who was hard of hearing or required a hearing loop. Those who did not have English as their first language and were not confident to speak English tended to bring family or friends who acted as interpreters. However there was a translation service available if required.

Patient/carer support to cope emotionally with care and treatment

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

Notices in the patient waiting area 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.

Staff told us they had a policy and a register which identified carers and they offered support when it was needed. As the staff tended to know all the patients they would also ring up patients to ensure they were being looked after and to encourage the older patients to be self-reliant.

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 engaged regularly with Sheffield 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.

Home visits were offered to patients who could not attend the practice. Longer appointments were also available to those who required them. Due to the nature and layout of the practice, if the advanced nurse practitioner needed the patient to see the GP at that particular instance, they would speak with the GP and would be seen almost immediately.

The practice provided a service for all age and population groups. Registers were maintained of patients who had a learning disability, a long term condition or required palliative care. These patients were discussed at the weekly clinical and multidisciplinary meetings to ensure practitioners responded appropriately to the care needs of those patients.

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 or who may be at risk. The practice had recognised the needs of different groups in the planning of its services, for example asylum seekers resident in the area, those with a learning disability, and carers.

The premises and services met the needs of patient with disabilities. The practice was situated on the ground floor of the building with services for patients on this floor.

We saw the waiting area was small but able to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients who attended the practice.

The practice had a majority population of English speaking patients though it could cater for other different languages through translation services.

Access to the service

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. Ninety-eight per cent of respondents said the last appointment they got was convenient 91% (CCG) and 90% of respondents found it easy to get through to the practice by telephone, and this was higher than the CCG average of 71%. Patients we spoke with and comments from the CQC patient comment cards aligned with these views.

Information regarding the practice opening times and how to make an appointment was available in the reception area and the practice leaflet. Appointments were available from 8:00 am to 6:00 pm Monday, Tuesday, Wednesday and Friday. With reduced hours on Thursdays from 8:00am to midday. The GP stated all those who needed to be seen on the day were seen. Especially all young children.

Patients could book appointments by telephone, or in person at reception. Some appointments were pre-bookable. There were urgent and same day appointments available. The practice also reminded patients of their appointments by use of a text message.

Comprehensive information was available to patients about appointments at the practice. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients and was on the practice telephone system when the practice was closed.

Longer appointments were also available for patients who needed them and those with long term conditions. This also included appointments with the GP or nurse. Home visits were made either by the nurse, health care assistant or GP to those patients who needed one. Appointments were available after. The practice encouraged involvement of parents with contraception advice for teenagers.

Patients were generally satisfied with the appointments system. They confirmed they could see a nurse or doctor on the same day if they needed to. Comments received from patients showed that patients in urgent need of treatment were able to make appointments on the same day they contacted the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

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

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

We looked at five complaints received in the last 12 months and found they were satisfactorily handled, dealt with in a timely way and displayed openness and transparency with dealing with the compliant.

The practice continually reviewed complaints to detect themes or trend and lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy. The practice vision and values included to provide a high standard of medical care and be committed to their patients' needs. The visions and values were discussed at staff meetings and also by staff during their daily routines.

We spoke with two members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop of any computer within the practice. We looked at some of these policies and procedures. All the policies and procedures we looked at had been reviewed annually and were up to date.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it performed in line with national standards. We saw QOF data was discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The practice had achieved 99% of QOF points.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example the GP spoke with the community pharmacist regarding the findings of audits into diclofenac and quinolone usage at the practice. As a result the GP spoke with a locum who agreed not to prescribe further as per practice policy.

The practice had arrangements for how they identified, recorded and managed risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, for example the fire risk and trip hazards. We saw the risk log was regularly discussed and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example with the risk of electrocution the practice disposed of a heater immediately and checked the others.

The practice held governance meetings. We spoke with staff who told us performance, quality and risks had been discussed.

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.

We reviewed a number of policies, for example recruitment policy, adult safeguarding policy and children's safeguarding policy which were in place to support staff. Staff we spoke with knew where to find these policies if required. The staff handbook had recently been revised.

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

The practice had gathered feedback from patients through, comment cards and complaints received). We looked at the results of the patient survey which identified there needed to be an improvement in confidentiality when patients booked in at reception. As a result a sign was displayed and patients were asked not to cross a yellow line until it was their turn.

The practice had gathered feedback from staff through generally through staff meetings, appraisals and discussions. One example was not to have unannounced fire alarm tests as they could have been obtaining bloods at the time. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and

Are services well-led?

Good

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

mentoring. We looked at staff files and saw regular appraisals took place which included a personal development plan. Staff told us the practice was very supportive of training and they had staff learning days.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and training days to ensure the practice improved outcomes for patients.

The practice had completed reviews of significant events and other incidents and shared the information with staff to ensure the practice improved outcomes for patients. We saw evidence of this in logs of events. Examples included the change in the computer system and when other agencies were contacted when patients were seen with a young child in abnormal circumstances.