Gibson Lane Practice

Quality Report

Gibson Lane
Kippax
Leeds
West Yorkshire
LS25 7JN
Tel: Tel: 0113 287 0870
Website: www.gibsonlanepractice.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

We inspected this practice and the two branches at Garforth and Monk Fryston on the 28 and 29 October 2014 as part of our comprehensive inspection programme.

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

Our key findings were as follows:

- Patients were satisfied with the approaches adopted by staff and said they were caring and helpful. We received a number of comments from patients who told us that the GPs took their time to listen to them.
- The practice offers flexible appointment times and is open until 8pm one day per week and Saturday mornings. Appointments are available to book in advance. The practice also offers telephone consultations and an online appointment and prescription service.
- The practice has a clear vision to deliver high quality care and promote good outcomes for patients. We found that these values are embedded within the culture of the practice. There are good governance and risk management processes in place. We found that the provider listens to patient comments and takes action to improve their service.
- We looked at how well services are provided for specific groups of people and what good care looks like for them. We found that the practice actively monitors the needs of patients. We saw that they make arrangements for older patients and patients who have long term health conditions to be regularly reviewed and to attend the practice for routine checks. We found that appointments provide flexibility for patients who are working.

We saw some areas of outstanding practice including:

- The practice had identified patients over the age of 74 years and those they considered to be at high risk of deterioration or admission to hospital due to the complexities of their health needs. Individual plans of care had been developed for these patients. Each patient considered at high risk had a named GP and a

Summary of findings

member of the reception staff as a named care coordinator. Patients were contacted at regular intervals by either their named GP or care coordinator to monitor the patients' health and wellbeing.

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

- We found systems for infection prevention and control did not always follow recommended guidance.
- Arrangements to control access to the controlled drug cupboard at the Monks Fryston site were not robust.

Letter from the Chief Inspector of General Practice

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. The practice had systems in place to ensure staff would recognise and act on any signs of abuse. There were systems in place to ensure medicines were appropriately prescribed and dispensed. The practice was visibly clean and reasonably maintained. Systems were in place to provide adequate staffing and to ensure recruitment checks were completed. Effective systems were in place to provide oversight of the safety of the building and plans were in place to deal with emergencies.

However we found there were some areas for improvement. We found systems for infection prevention and control did not always follow recommended guidance. Arrangements for the security of medicine storage area keys at the dispensary at the Monks Fryston site were not robust.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and used it routinely. People's 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 appropriate to their roles and any further training needs had been identified and planned. The team made effective use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

The practice had a well-established patient forum group and people from this group told us they were actively involved in the development and improvement of the practice.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had worked to improve access for patients and patients told us there was continuity of care, with urgent appointments available the same day. We saw that there was a well-developed practice web site with a wide variety of health information for patients with links to relevant organisations. The practice had good facilities and was well equipped to treat patients and meet their needs.

The practice was proactive in seeking the views of patients and had responded to suggestions that improved the service and improved access to the service. The practice conducted regular patient surveys and had taken action to make suggested improvements.

The practice had a clear complaints policy and responded appropriately to written complaints about the service. However they did not record and monitor verbal concerns and complaints. The complaints procedure was not openly displayed in the practice.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 that outcomes for patients were good for conditions commonly found in older people and the practice scored above average for the percentage of patients aged 65 and older who have received a seasonal flu vaccination. The practice offered proactive, personalised care to meet the needs of the older people in its population. People over 75 years of age had a named GP and one of the administration staff were allocated as a care coordinator to support the GP in this role and monitoring checks were completed on a regular basis. The practice offered home visits and they provided services to support those patients living in a local nursing home by completing a weekly visit to the home.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Information from the quality and outcomes framework (QOF) showed that the practice was scoring above the CCG average in a number of QOF indicators relating to care, treatment and monitoring patients with long term conditions. The practice had identified patients they considered to be at high risk of deterioration or admission to hospital due to the complexities of their health needs. Individual plans of care had been developed for these patients. Each patient considered at high risk had a named GP and a member of the reception staff as a named care coordinator. Patients were contacted at regular intervals by either their named GP or care coordinator to monitor their health and wellbeing. The practice worked with relevant health and care professionals to deliver a multidisciplinary package of care.

There was a structured annual review programme to check that patient's health and medication needs were being met. The practice combined clinics for patients with multiple health conditions to minimise the number of times patients were required to attend. The practice web site provided a variety of health information for patients.

We found that the Gibson Lane and Monk Fryston sites were accessible to patients with mobility difficulties although the Garforth surgery was difficult for wheelchair users to access.

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

Summary of findings

children who were at risk, for example, children and young people who had a high number of A&E attendances. Nationally reported data showed immunisation rates were high for standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. Emergency processes were in place and referrals were made for children whose health deteriorated suddenly.

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 needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. A range of appoint times were available for patients including late evening and Saturday mornings and some appointments could booked in advance.

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 such as those with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

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

The practice had very few patients whose first language was not English but patients could have access to translation services via language line to assist during the consultation.

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 had told patients experiencing poor mental health about how to access various support groups. It had a system in place to follow up

Summary of findings

patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Some staff had received training on how to care for people with mental health needs and dementia.	

Summary of findings

What people who use the service say

Prior to the inspection we received information from the 2013/14 National Patient Survey. People registered at general practices across England were asked a number of questions about their practice. For this practice 267 surveys were sent out and 113 were received back. The results for this practice were above local Clinical Commissioning Group (CCG) average for patients having confidence and trust in the last nurse they saw or spoke to, the last nurse they saw or spoke to was good at treating them with care and concern and patients usually waiting 15 minutes or less after their appointment time to be seen. However they were below average for the local CCG for patients who would recommend their GP surgery, opening hours, ability to get through on the phone, experience of making an appointment and the overall experience of their GP surgery. However results were more positive in the 2014 survey completed by the practice patient forum with an increased percentage stating they were happy with the appointment system and opening times. The majority of patients we spoke with during the inspection were satisfied with the appointment system and said they could get an appointment the same day

Prior to the inspection we provided CQC comment cards to the practice which the manager distributed between the providers three sites. We received 39 completed CQC comment cards. We also spoke with fifteen patients across the three sites during our visit, including two representatives from the patient forum. We spoke with people from different age groups and with people who had different physical needs and those who had varying levels of contact with the practice.

The majority of patients were very complimentary about the care and treatment provided by the clinical staff and the overall friendliness and behaviour of all staff. The majority of patients said the doctors and nurses were caring and knowledgeable about their treatment needs. Patients said the staff listened to them and were very helpful.

The majority of patients told us the care they had received was appropriate and met their needs. They said that they received regular health checks.

They said that they were treated with respect by the staff and the patient forum representatives felt their views were taken into account and acted on.

The majority of patients were satisfied with the appointments system and its ease of access and the flexibility provided. However some patients told us that they often had difficulty getting through to the practice by telephone early morning. We were told by the patient forum representative that following a recent survey the practice had worked to improve the uptake of the online booking service to improve the appointments system.

Some patients told us that the practice was not always clean and tidy and some felt that this had improved just prior to the inspection. (We were not able to identify if these comments were related to Gibson Lane site or the Monk Fryston site as the comment cards from these sites had been combined).

Areas for improvement

Action the service SHOULD take to improve

- Arrangements to control access to the controlled drug cupboard at the Monk Fryston site were not robust.
- Systems for infection prevention and control did not always follow recommended guidance. Storage arrangements for cleaning equipment were not adequate, recommended systems for colour coding cleaning equipment had not been fully implemented, some cleaning equipment was dirty, cleaning schedules had not been implemented at two sites, monitoring of the standards of cleaning was not adequately completed, recommended guidelines for disposal of sharps containers was not followed and some taps, sinks and flooring did not meet recommended guidance.

Summary of findings

Outstanding practice

- The practice had identified patients they considered to be at high risk of deterioration or admission to hospital due to the complexities of their health needs. Individual plans of care had been developed for these patients. Each patient considered at high risk had a named GP and a member of the reception staff as a named care coordinator. Patients were contacted at regular intervals by either their named GP or care coordinator to monitor their health and wellbeing which ensured the care was both effective and responsive.

Gibson Lane Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC inspector, a GP specialist advisor and an expert by experience.

Background to Gibson Lane Practice

Gibson Lane Practice, (also known as Kippax Health Centre), also operates at two branch sites, Garforth surgery (also known as Hazelwood surgery) and Monk Fryston surgery.

Gibson Lane Practice operates mainly from Kippax Health Centre which is a purpose built health centre. The practice is accessible to all patients. Parking is available with allocated spaces for disabled patients.

Garforth Surgery is a converted bungalow in a residential area situated approximately one and a half miles from the main health centre. There is no off road parking and the building is not accessible to all patients with a disability.

Monk Fryston Surgery is a converted and extended bungalow in a residential area. It is located approximately seven miles from the main health centre. Parking and disabled access is provided. This surgery also provides a small dispensary.

We visited all three sites as part of this inspection.

The practice is part of the Leeds South and East Clinical Commissioning Group (CCG). It provides services under a Primary Medical Service contract with NHS England and has a patient list size of 11411.

There are six female and two male GPs who work across the three sites. The clinical team also includes four nurses, three phlebotomists and two health care assistants. An experienced team of administrative and reception staff support the practice.The administrative team consists of a practice manager, a deputy manager, twelve full-time and part-time receptionists and four receptionist/dispensers working across the three sites. Two data input assistants, two secretaries and three administrators are based at the Gibson Lane Practice

Normal working hours at the Gibson Lane site are Monday 8 am – 8 pm, Tuesday, Wednesday Thursday and Friday 8 am – 6 pm, and Saturdays 8 am – 11 am.

Normal working hours at the Garforth site are Monday, Tuesday and Thursday and Friday 8 am – 6 pm and Wednesday 8 am – 12 pm.

The Monk Fryston site is open on Mondays alternate weeks 4 pm – 8 pm or 2 pm – 6pm. On Tuesdays and Fridays it is open 8 am - 12 pm and on Thursdays is open 2 pm – 6pm. This site is closed all day on Wednesdays.

Appointment times after 6pm and on Saturday mornings are for pre-booked appointments only.

Patients can access Out of Hours services by telephoning the NHS 111 service.

Patients have access to primary care services such as health visitors and district nurses and a pharmacy at the Gibson Lane site.

Gibson Lane Practice is also a teaching practice and the Practice is a member of Primary Care Research Network and participates in NHS research studies.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service 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.

This provider was chosen for inspection as part of a random selection of practices operating in the Leeds South and East Clinical Commissioning Group (CCG) area.

How we carried out this inspection

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

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

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

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

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

We carried out an announced visit on 28 and 29 October 2014 and visited all three sites. During our visit we spoke with a range of clinical staff including four GPs, two doctors training in general practice, two practice nurses and one health care assistant. We also spoke with the practice manager, deputy manager, four reception staff, one dispenser, a medical secretary and a data input assistant. We also spoke with 15 patients who used the service including two members of the practice patient forum.

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception areas at all three sites. We reviewed 39 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also reviewed records relating to the management of the service.

We attended a clinicians meeting held in the practice during our site visit.

Requires improvement

Are services safe?

Our findings

Safe track record

We found the practice used information from different sources, including patient safety incidents, complaints and clinical audit to identify incidents. They had systems in place to record, monitor and learn from incidents which had occurred within the practice. Staff were able to give examples of incidents that had occurred and the processes used to report and record these. We saw records of incidents, investigation and actions taken to minimise risks of reoccurrence.

The practice held regular meetings to discuss information relating to risk factors for the patients' health and welfare. We observed clinicians reviewing patient's records against information about patient's attendance at accident and emergency and out of hour's services. We saw they identified any risk factors and agreed action plans to minimise risks for these patients.

Learning and improvement from safety incidents

There were systems in place to learn from incidents which had occurred within the practice and one of the GPs had a lead role in this area. We were told, and we saw from records, incidents were investigated and then discussed at all levels of the practice and any learning points were actioned. We were told by GPs that any urgent action would initially be taken by the GPs or nurses. They said incidents would then be discussed at the practice meetings and the fortnightly clinical meetings. We observed that a comprehensive log of significant events was maintained and the GPs told us this was monitored for patterns or trends.

Staff confirmed incidents and any actions taken were discussed and reviewed as a team at meetings. Any further actions to improve practice were then agreed and procedures updated as required. The staff group valued this involvement and felt their views were taken into account. Staff were able to tell us how practice had changed following incidents to minimise risks of reoccurrence. For example, a staff member described how practice had been changed for the management of faxed referrals to secondary care following an incident where a fax was sent but not received. We were told that the incident had been investigated and a new protocol had been written and a revised work stream implemented to minimise the risk of reoccurrence.

The GPs told us they had an agreed system with the local CCG to report concerns in relation to patient discharges and hospital care which also included incidents relating to out-patients services and diagnostics. We observed that these records were very comprehensive. During the clinical meeting we observed that issues to be reported through this system were considered and identified.

Reliable safety systems and processes including safeguarding

The practice had a GP as the safeguarding lead. We saw that information was available to all staff which advised staff how to escalate any safeguarding concerns. The staff we spoke with were aware of how to escalate any concerns regarding safeguarding and said they would approach the practice manager in the first instance. Clinical and non-clinical staff were able to describe the actions they had taken in different cases when they were concerned about children after parents had cancelled their routine appointments or failed to attend appointments. Their descriptions indicated that they were able to recognise risk and act appropriately.

Records showed staff had received training in safeguarding both adults and children. Nurses and GPs received training in safeguarding adults and children relevant to their role.

Information which may indicate a risk for a vulnerable adult or child was shared and monitored at the monthly safeguarding meeting which was attended by a health visitor. The patient records also indicated if there were any safeguarding concerns. We observed that patient safety and any possible signs of abuse were considered by clinicians during the practice meeting we attended. We saw the patient's previous history was taken into account when reviewing hospital attendance and patients contact with out of hour's services.

Procedures for chaperoning patients were in place and staff had received training in this area. Notices were displayed in the practice explaining the chaperoning procedures.

A system was in place to respond to safety alerts from external sources which may have implications or risk for

the practice. These included NHS England, Medicines and Healthcare Products Regulatory Agency (MHRA) and National Patient Safety Agency (NPSA). The practice manager told us that as alerts came into the practice she checked these and ensured required actions were taken where required. She told us an electronic copy of the alerts and guidance was maintained and was accessible to staff. The manager was not able to show us evidence of this or the actions taken on the computerised system on the day but provided evidence after the inspection in the form of a screen shot of the list of alerts stored. Staff told us that alerts were sent by the instant messaging system and said this system indicated to the manager when they had read these. Staff also described some of the actions undertaken in response to the alerts.

The staff had received training in health and safety, manual handling and fire safety procedures.

The appointments systems allowed a responsive approach to risk management. For example, where there were no appointments available for people on the same day, a triage system was managed by the GP on duty.

Medicines management

During this inspection we looked at procedures relating to medicines and checked a random selection of stored medicines across the three sites.

The Monks Fryston site had a small dispensary. We observed that the dispensary was clean, tidy and well organised. Dispensing staff at the practice told us and we saw that prescriptions were signed before being dispensed.

The practice had a system in place to assess the quality of the dispensing process which included a monthly audit of controlled drugs and expiry dates of all medicines held. An annual audit of the dispensary was also undertaken.

Staff involved in the dispensing process told us and we saw from the training records that they had received appropriate training such as National Vocational Qualifications (NVQ) and Dispensary Services Quality Scheme (DSQS) training.

The practice had established a service for people to pick up their dispensed prescriptions at Monk Fryston and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure people collecting medicines were given the correct medicines and all the relevant information they required and we observed this in practice.

We saw that arrangements to control access to the controlled drug cupboard were not robust. We observed that the dispensary keys and controlled drug storage keys were not held securely during the day although they were out of sight of patients and not in an area used by patients. We were told that these keys were passed between dispensary and reception staff at the end of a shift to be held and given to the person coming on duty the next day but there was no record of who was responsible for the keys at any one time. National Prescribing Centre (NPC) guidance, A guide to good practice in the management of controlled drugs in primary care (England), December 2009, states, “One designated person on the premises should take overall responsibility for the keys/codes. The number of sets of keys to the container, and who holds them, or who has access codes for digital key pads, must be known at all times by the designated person. The keys should always be kept separate from the container and should never be accessible to unauthorised persons.”

We observed that there was good practice across the three sites in relation to medicines which required refrigeration. Daily visual checks of temperatures were recorded. Each fridge also contained a device which continually monitored and recorded the fridge temperatures electronically so that any breach in the cold chain could be identified. Staff could clearly describe the actions required should there be a breach and we saw evidence that action had been taken where a breach had occurred.

We saw that medicines required for treatment of a medical emergency were available and were regularly checked to ensure these remained within their expiry date and electronic systems were in place to identify any medicines near to their expiry date.

We saw that the practice completed regular clinical audits relating to medicines and prescribing practice. For example, an audit of prescribing trends had been completed and this had led to a more consistent approach by the GPs when considering the length of time a medicine should be prescribed for. The practice was also part of the amber drug scheme. This was where the responsibility for prescribing specific drugs which need monitoring by, for example, specific blood tests, is shared between the

hospital specialist and the GP. The Clinical Commission Group (CCG) initiated the scheme and as part of this the practice was required to send quarterly audits to the medicine management team at the CCG.

We saw that there was good practice in place for the management of repeat prescriptions. Reception staff were clear about their role in this process and the checks required before giving prescriptions to patients or pharmacy staff.

During a tour of the building at the Gibson Road site we saw that prescriptions for signing had been left on a desk in a consulting room. These were immediately removed by the practice manager and they reported this to the Registrar's mentor.

Cleanliness and infection control

We received varied comments from patients on competed CQC comment cards about the cleanliness of the practice although we could not identify which site the comments related to. Some patients told us that the standard of cleaning had improved just prior to the inspection.The practice had an infection control policy and guidelines in place and one of the nurses had a lead role for infection control in the practice. Staff had completed training in infection prevention and control.

An external audit of the infection control processes had been completed in 2012 and an internal audit had been completed in August 2014. Action plans had been developed to address shortfalls although dates for completion were not identified. The practice manager and infection control lead could describe the actions taken and assured us the majority of work in the actionplans had been completed.

We found some infection control policies and procedures were not consistently followed and systems to check adherence to policies and procedures were not always completed.

The practice employed domestic staff at the Monk Fryston and Garforth sites. The manager told us and provided evidence to show that, cleaning frequency schedules were under development for these sites. There was no evidence that the practice regularly monitored the standard of cleaning although we observed areas accessed by patients at these sites to be reasonably clean and tidy. There was no evidence at either site that the nationally recommended colour coding scheme for cleaning equipment had been implemented to minimise the risk of cross infection. We found there was inadequate provision for correct storage of some cleaning equipment and some equipment was dirty. We observed that the hard floor covering in the treatment room at the Garforth Site had peeled away from the walls and was stained.

At the Gibson Lane site cleaning services were undertaken and managed by an external company employed by NHS Services and the practice. The practice manager informed us that monthly checks of the standards of cleaning were undertaken by the cleaning company's manager and they received verbal feedback. There was no evidence that the practice regularly monitored the standard of cleaning or checked adherence to the cleaning schedule. We saw that there was inadequate provision for correct storage of some cleaning equipment and some cleaning equipment was dirty. We observed the consulting and treatment rooms were visibly clean and reasonably maintained. However the waiting room carpet was stained and together with the entrance area, required vacuuming.

We saw that work to improve infection prevention and control had been identified at all three sites in the external audit in 2012 and again in the internal audit in 2014. No date for completing the work required was identified in the plans. This included changing carpets to hard flooring to aid cleaning and changing taps and sinks which did not meet relevant guidance such as Health Technical Memoranda (HTM) 64. During the inspection the manager told us that a funding stream for this type of work had recently become available in the locality. We observed that staff were obtaining quotes for this work to be completed and developing a business case to enable them to apply for the funding.

The practice had procedures in place for the safe storage and disposal of needles and other sharps and waste products. We found that these procedures were being followed in relation to dating and signing the containers used for disposal of needles and sharps when they were put into use and audits of this process were completed. However we found the containers had not been disposed of in line with best practice guidance published by National Institute for Health and Care Excellence (NICE) in clinical guideline 139. This guidance states containers, "…should be disposed of every 3 months even if not full". We found

the majority of containers in consulting rooms exceeded this timescale and some containers were dated 2012. The infection control lead was aware of the NICE guidance but when we looked at the practice policy and procedures we found that this timescale was not specifically included. A number of the containers were removed during the course of the inspection and we were assured that this check would be added to their three monthly audits.

We were told by the practice manager and saw evidence that Legionella testing of the mains water supply and outlets was completed by NHS Community Services. The practice manager said the practice also took interim measures such as flushing the shower to minimise the risks.

Equipment

We saw that equipment had up to date portable appliance tests (PAT) completed and systems were in place for the routine servicing and calibration of equipment, where needed.

We checked the defibrillator and oxygen were readily available for use in a medical emergency at the Gibson Lane site. We saw records that the defibrillator equipment was checked each day to ensure it was in working condition and that other equipment was checked monthly.

Safety notices relating to equipment were displayed.

Staffing and recruitment

We found that there was a procedure in place to support the recruitment of staff although this was very basic and did not adequately describe the process for essential checks. For example, disclosure and barring service (DBS) checks and professional registration checks such as nurse's registration with the Nursing and midwifery Council (NMC).

When we looked at a sample of staff recruitment files we found most pre-employment checks had been completed. However there was no evidence of DBS checks on two of the staff files we saw. The practice manager told us that the DBS checks were obtained but the information was not stored by the practice in line with the DBS guidelines. The practice manager was unaware that the guidelines stated that details such as a record of the date of issue of a certificate, the type of certificate requested the unique reference number of the certificates and the details of the recruitment decision taken should be recorded. They were able to provide evidence that the DBS checks had been obtained for the two staff following the inspection.

Records showed ongoing checks were completed of staff registration with professional bodies, such as the NMC which confirmed they were able to continue to practice.

A pack was available, which provided locum GPs with relevant and up to date information about the policies and procedures in the practice and relevant contact details.

Staff told us there were sufficient staff employed by the practice to provide cover for sickness and holidays.

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

Monitoring safety and responding to risk

The practice had developed clear lines of accountability for all aspects of care and treatment. The GPs and nurses were also allocated lead roles in areas such as safeguarding, information governance and infection control.

A system was in place to respond to safety alerts from external sources which may have implications or risk for the practice. These included NHS England, Medicines and Healthcare Products Regulatory Agency (MHRA) and National Patient Safety Agency (NPSA). The practice manager told us they ensured alerts were actioned as required. Staff confirmed they were informed of alerts and that they were acted on.

The staff had received training in health and safety, safeguarding vulnerable adults and children, chaperoning patients and fire safety procedures.

The appointments systems in place allowed a responsive approach to risk management. For example, where there were no appointments available for people on the same day, a triage system was managed by the GPs.

The practice held regular meetings to discuss any emerging risks, for example, a fortnightly clinical meeting and monthly safeguarding meeting. We observed, during attendance at a clinical meeting, that information relating to risk factors for the patients' health and welfare was discussed and action plans to minimise risk were agreed.

Requires improvement

Are services safe?

Arrangements to deal with emergencies and major incidents

Business continuity plans were in place to deal with emergencies that might interrupt the smooth running of the service such as power cuts and adverse weather conditions. The practice manager told us that they could transfer services to one of the other practices sites should the need arise. We were also told that all the electronically held practice information was backed up to a central server on a daily basis.

We found that the practice ensured that the clinical staff received regular cardiopulmonary resuscitation (CPR) training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could outline the rationale for their treatment approaches and they had access to and were familiar with current best practice guidance. For example, the nurses told us they could access NICE and The British Thoracic Society (BTS) guidelines for chronic obstructive pulmonary disease (COPD) electronically.

We were told that the practice had identified individual's needs in relation to their physical and mental health needs and had developed care plans to support them. We saw during our attendance at a clinicians meeting that people's needs were reviewed when they had been identified as attending accident emergency or out of hours services. The staff we spoke with confirmed that these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them.

Patients told us that they felt the GPs listened to them during consultations.

Management, monitoring and improving outcomes for people

Information from the quality and outcomes framework (QOF) showed that the practice was appropriately identifying and monitoring patients with long term health conditions. The most recent data available to CQC showed the practice was scoring above the CCG average in a number of QOF indicators relating to care, treatment and monitoring patients with long term conditions.

We found that individual plans of care had been developed for patients with complex needs. Where patients were at high risk or had complex needs these patients were monitored by named members of staff. We found that patients with long term conditions were invited to regular reviews.

The practice had identified patients they considered to be at high risk of deterioration or admission to hospital due to the complexities of their health needs. Individual plans of care had been developed for these patients. Each patient considered at high risk had a named GP and a member of the reception staff was a named care coordinator. We were told that each of these patients were contacted at regular intervals by either their named GP or care coordinator to monitor their health and wellbeing. The majority of patients told us the care they had received was appropriate and met their needs. They said they received regular health checks and were prompted to attend these by the staff.

The practice had a system in place for completing clinical audit cycles to monitor outcomes for patients following assessment or treatment. Examples of clinical audits undertaken in 2014 included antibiotic prescribing, end of life care and bowel cancer screening. The practice was also involved in assisting in NHS research studies as a member of the Primary Care Research Network.

The practice regularly reviewed patients who had attended accident and emergency and out of hours services. We saw that they identified where a patient who may need a health check due to the number of times they had accessed the out of hours services in a short period of time and agreed this patient would be invited to attend the practice.

Effective staffing

From our review of staff training records, we found staff completed an induction programme relevant to their role. They also completed training considered to be essential, such as fire awareness, information governance and safeguarding adults and children. Staff told us they had access to additional training for personal development. For example, one person described how they had been able to develop into a senior role with support from the practice manager and access to vocational training. Another person told us they had been well supported by the lead nurse and had received training to develop their clinical role.

We saw from a review of staff files that internal annual appraisals were completed for nursing, health care and administration and support staff. Appraisals were completed by the person's line manager and included the individual's review of their own performance, feedback from the line manager and planning for future development.

We saw there was a formal monitoring system in place to ensure that healthcare professionals had up to date professional registration with professional bodies such as the Nursing and Midwifery Council (NMC).

Many of the staff had worked at the practice for a number of years and they told us they enjoyed their work and felt well supported.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

Staff told us that everyone worked as a team in the practice and all the staff we spoke with felt they were listened to and involved in the running of the practice. There were clear lines of accountability and staff understood their role. The practice used a buddy system for each non-clinical role so that there was always someone available with knowledge of the work to be completed to cover annual leave or sickness absence.

The practice used a computer system to store patient records. Specific staff were employed to input data such as discharge letters and blood results into the electronic records. Tasks were then sent electronically for the GPs to review the information. Staff told us that urgent information would also be taken to the GP to ensure that this was seen as soon as possible.

Staff told us they had regular meetings and were able to describe the content of the discussions in the meetings and any actions taken in response. We attended a practice clinicians meeting during the inspection and observed open discussion between the staff.

The practice manager told us they worked with five local practices as part of a learning set and bi-monthly meetings were held to discuss various topics. They told us they were also working with the CCG on a project to look at providing extended hours at the practice.

Information sharing

Staff had access to systems relevant to their role and all staff had access to up to date practice policies and procedures stored on the computer systems. Staff told us they were kept informed by the practice manager if there had been any changes to policies and procedures. We also saw that the practice had a library of reference books.

The practice worked with other health professionals to share information relating to patient care during regular primary care, safeguarding and palliative care multi-disciplinary meetings. The electronic system enabled timely transfer of information with out of hour's services.

Consent to care and treatment

Clinicians we spoke with were able to describe the process for gaining consent to care and treatment. They showed an understanding of mental capacity and issues relating to gaining to consent for both adults and children. We were told that consent forms were scanned onto computerised patient records. Through our discussion with one member of the clinical staff team we found they had an understanding of the deprivation of liberty safeguards but not of the changes to the legislation in March 2014 which lowered the threshold for assessing whether a person was being deprived of their liberty.

Health promotion and prevention

We saw that there was a well-developed practice web site with a variety of health information for patients. For example, information relating to long term conditions such as diabetes and chronic obstructive pulmonary disease (COPD) was available. Links to relevant websites, where patients could access a wide range of information and advice were also displayed. For example, links to NHS Choices and a local counselling service.

Nationally reported data showed that the practice scored above average for the percentage of patients aged 65 and older who have received a seasonal flu vaccination. They also had a high rate, in relation to local CCG levels, for childhood immunisations.

We saw that information for patients was displayed on notice boards in the reception area and throughout the practice and a number of health and social care information leaflets were also available.

The practice also offered a range of services to support patients such as disease management and health promotion clinics which included asthma, diabetes, family planning and routine health checks.

The practice actively promoted local campaigns such as the bowel screening campaign and Leeds Lets Change initiative through information displayed in the practice and on the web site.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients told us they were very satisfied with the care and treatment they received from the staff. Patients told us they found the staff to be caring and very helpful. They said they felt clinicians were professional, caring and respectful. We had a number of comments from patients who told us that the GPs took their time to listen to them.

The GP told us that where people were assessed as requiring palliative care they supported patients to remain in their own home if they wished. They told us they prescribed anticipatory medicines to enable the patient to be kept as comfortable as possible.

We observed staff interactions with patients in the waiting area and on the telephone to be patient, kind and respectful.

The waiting area was close to the reception area and some patients could be overheard speaking to reception staff. However patients could speak with reception staff in private in another room if required.

Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. There were signs explaining that patients could ask for a chaperone during examinations if they wanted one and staff had received chaperone training.

Care planning and involvement in decisions about care and treatment

Patients told us they were involved in planning their care and told us they felt fully informed about their care and treatment.

We attended a practice clinicians meeting during the inspection. We observed that care plans for patients with complex needs who had attended out of hour's services or accident and emergency were reviewed and monitored for effectiveness.

Staff told us that they had very few patients whose first language was not English but said where necessary patients could have access to translation services via language line to assist during the consultation.

Patient/carer support to cope emotionally with care and treatment

Staff told us that people over 75 years of age had a named GP and one of the administration staff were allocated as a care coordinator to support the GP in this role. Staff told us that the GP or care coordinator would contact patients on a regular basis (approximately every three months) to check how the patient was. They said patients could also ring and speak to their named GP or care coordinator.

Patients told us they felt supported. For example, one patient told us that they had felt supported following a hospital admission for an acute illness. They also said that their GP had contacted them to check if their medicines were effective. A parent told us that they had been supported and reassured when their baby was ill and said the practice had been very flexible in their arrangements to see the child.

The practice had information for carers which included contacts for carers support and information.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the Gibson Lane and Monk Fryston sites were accessible to patients with mobility difficulties. There was allocated parking spaces for disabled patients at Gibson Lane. The Garforth surgery had a ramp to the front door but the style of the doorframe made this difficult for wheelchair users to negotiate. One person told us that the GP carried out home visits to ensure their relative, who was a wheelchair user, was seen as required.

Staff said they had access to translation services for patients who needed it and a hearing loop was available at reception for those who had a hearing impairment.

The practice held regular clinics for a variety of complex and long-term conditions such as respiratory disease and diabetes. Staff told us they tried to combine clinics for patients with multiple health conditions to minimise the number of times patients were required to attend. There were systems in place to ensure that patients were called for routine health checks and non-attendance was monitored and acted on through phone calls or letters to the patient. People with long term conditions told us they felt well supported and said that their health condition was well managed.

We attended a clinicians meeting during the inspection and observed that patients care needs were reviewed during discussions about patient attendance at out of hour's services. We saw where it was identified that a patients needs may have changed they would be invited in to the practice for a health review.

The practice had an active Patients' Forum which met twice a year. We spoke with two members who told us they had been involved with planning patient surveys and developing an action plan following feedback. They told us that as a result of feedback from surveys the practice had implemented improved systems for booking appointments.

Tackling inequity and promoting equality

A range of appoint times were available for patients including late evening and Saturday mornings and some appointments could booked in advance. Home visits were also available at the discretion of the GP and patients confirmed this to be the case.

A GP told us they provided services to support those patients living in a local care home by completing a weekly visit to the home.

Staff said they had access to translation services for patients who needed it and equipment for those who had a hearing impairment.

Access to the service

Patients registered at general practices across England were asked in the 2013 GP patient surveys how easy or difficult it was for patients to see or speak to a doctor at their practice. Results recorded from this survey for this practice were below average for their local CCG area. For example, the percentage of patients rating their ability to get through on the phone as very easy or easy was 65% and 54% rated their experience of making an appointment as good or very good. The score for opening hours was 63%.

However results were more positive in the 2014 practice survey with 66% stating they were happy with the appointment system and 76% happy with the opening times. The majority of patients we spoke with during the inspection were satisfied with the appointment system and said they could get an appointment the same day.

The annual patient forum reports showed action plans to improve access to the service had been implemented following previous annual patient surveys. For example, following the 2013 survey, the times patients could access the telephone booking system was reviewed and changed to improve patient access. The reports also showed that appointment times were reviewed and adjusted to meet patient needs.

We found that the practice offered pre-bookable appointments until 8 pm one evening per week at two sites. Saturday morning appointments were available at the main site. The practice also offered telephone consultations and an online appointment and prescription service. Patients told us that the online system for booking appointments was straightforward and appointments were available to book two weeks in advance. They also said that an appointment could usually be made with a GP of their choice although they may have to wait a few days. They said that surgery generally ran on time and reception staff always explained any delays.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Information about appointment times were displayed at the practice, on the practice website and in newsletters. Information about appointment times and systems in place to book an appointment had been improved following the patient survey.

There were processes in place for home visits by the GPs and a GP visited patients living in a local care home every week.

The practice web site was well developed and easy to navigate. It provided a wide range of information about the practice, policies and procedures, i.e. data protection procedures and health information including information about long term conditions. The web site also contained information relating to the patient forum group, survey results and action plans.

The practice manager told us they were working with the CCG on a project to look at providing extended hours at the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns and there was a designated responsible person who handled all complaints in the practice. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The complaints procedure was not displayed openly in the practice but a the procedure was contained in the practice booklet which was available on the reception desks and on the practice web site. A full explanation of the procedure and process for escalating concerns was available with the complaints form on request from the reception staff.

Prior to the inspection the practice manager sent us a summary of the complaints received since April 2013. This showed that three complaints had been received in relation to the care and treatment at the practice.

During the site visit we reviewed how complaints were received and documented. We were told by staff that they always tried to resolve concerns immediately with the patient. Where concerns could be immediately resolved the information was recorded directly onto the patient's electronic records. However these were not logged to enable the practice to monitor patterns and trends.

Where concerns could not be immediately resolved the patient was requested to record their complaint on the practice complaints form. These were passed to the practice manager. We saw that the practice manager investigated and responded appropriately to these complaints.

We saw that a comments box was available at the Garforth and Monks Fryston sites. Staff said that there was usually a comments box at Gibson Lane but on the day of the inspection they did not know where it was.

Staff told us that the practice manager would advise them if there were any required actions arising from complaints and procedures would be updated as necessary.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values within the practice statement of purpose. This document stated their aims and objecives included, providing a high standard of medical care and maintaining this through continuous learning and training , being committed to patients needs and being courteous, approachable, friendly and accommodating

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

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

Governance arrangements

There was a governance framework to support the delivery of the good quality care. Staff were clear about their roles and understood what they are accountable for. All the staff we spoke with commented positively on how all the staff worked together as a team. Staff told us the GPs and the practice manager were very approachable and they said their opinions were taken into account.

We found that all the staff, including the GPs, placed a heavy reliance on the practice manager for information relating to procedures in the practice and staff were often vague about processes beyond reporting to the manager. The manager had a team of staff to assist her in her role and they felt their role was to protect the GPs as much as possible to allow them to focus on the patients. The practice manager told us she worked very closely with the lead GP in the management of the practice.

Some GPs and nurses had lead roles in areas such as safeguarding, infection control and governance. However we found that the staff had little knowledge of who held the lead roles and some of those with lead roles were vague on what their involvement in their area should be. We found that when we asked staff who they would go to for support or advice they said the manager or the deputy manager.

There were assurance systems and performance measures, which were reported and monitored, and action was taken to improve performance. Patients and staff views were sought through surveys and the patient forum and were taken into consideration. A member of the patient forum said the management listened and acted upon survey findings.

Clinical and internal audits were used to monitor quality and systems in the practice and to identify where action should be taken. There were arrangements for identifying, recording and managing risks.

We found there were induction and initial training programmes for all staff and ongoing appraisal. Staff told us that they found their appraisals to be a positive experience. The practice provided training for doctors who were seeking a career in general practice.

Leadership, openness and transparency

The practice manager and GPs we spoke with understood the challenges to good quality care and listened to patients and staff. We found that there was an emphasis on educating patients to ensure they understood how the practice was managed to assist them to access the service appropriately.

Staff told us the management were visible and approachable. They said the manager had an open door policy and encouraged them to be involved in problem solving solutions. Staff told us they felt supported, respected and valued.

The staff told us the practice focused on the needs and experience of people who used services and shared learning experiences to improve outcomes for people.

The members of the patient forum told us that they felt listened to and said the practice worked with the patient forum to improve.

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

Are services well-led?

Good

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

The practice had a well-established patient forum group which met twice a year. A virtual group had also been established. From a review of the minutes of the meetings we found the groups were effective and engaged.

We found, from records and discussion with two members of the group, their views were listened to and used to improve the service. We also found they had been involved in designing practice surveys; making decisions about how best to get feedback from patients and plans for acting on the outcome of the surveys.

The annual patient forum reports showed action plans had been implemented. For example, we were told that following a recent survey the practice had worked to improve the uptake of the online booking service and to reduce the number of patients who did not attend for their appointments. This was to improve the appointments system and improvement in both areas had been achieved through the use of notices in the practice and in a newsletter.

The staff and the patient forum members said they found the GPs very approachable and open to their ideas to improve the practice. Staff told us they were actively encouraged to be involved in developing methods to improve practice and outcomes for patients. They told us they were kept informed about any learning points from incidents and complaints.

Management lead through learning and improvement

We saw that an induction programme was completed by new staff and the majority of staff had completed essential training. Essential training for all staff included; fire awareness, information governance and safeguarding vulnerable adults and children. Staff also had access to additional training related to their role and for personal development. Personal development plans were discussed at appraisal and staff confirmed these were implemented.

We saw the practice had regular clinical, practice and multidisciplinary meetings. We observed a clinical meeting during our visit and found this was effective in enabling the clinicians to monitor patient's needs. Patient admissions to hospital were discussed and reviewed as was patient attendance at accident and emergency and out of hour's services. Risks to patient's health and wellbeing were identified during this process and they were called for review where necessary.