Dr Dilip Chatterjee

Quality Report

Dunninc Road Surgery
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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 Dr Dilip Chatterjee on 6 May 2015. Overall the practice is rated as good.

Specifically we rated the practice as good in providing safe, effective, caring, responsive and well-led care for all of the population groups it serves.

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 care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Complaints were addressed in a timely manner and the practice endeavoured to resolve complaints to a satisfactory conclusion.
- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents 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.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

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

- Ensure training records are up to date, to enable the practice to accurately monitor review dates.
- Ensure all clinical staff have a good understanding of Gillick competency assessments of children and young people.

Summary of findings

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. Staff understood and fulfilled their responsibilities to raise concerns, 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 enough staff to keep patients safe.

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 the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed, care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. There was evidence of all staff having annual appraisals with the exception of the practice manager. Staff worked with multidisciplinary teams to provide effective care and support to patients.

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 consultation. 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 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 facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. Learning from complaints was shared with staff. The practice accepted patients from anywhere within the Sheffield area.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. 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.

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. All patients over 75 years of age had a named GP. The practice was responsive to the needs of older people, offering home visits and longer appointments. They also offered same day appointments if required or a telephone call from the doctor. The practice worked with relevant health and social care professionals to deliver a multidisciplinary package of care. For example, working with local community support workers (CSW) and SOAR (a local health community programme) to look at social isolation issues older people may encounter.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. Nursing staff had lead roles in chronic disease management such as diabetes and chronic obstructive pulmonary disease (COPD). 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. With their consent, patients who had either cancer or HIV and may have had social issues were referred to the local CSW or SOAR, who could offer counselling, benefit support and advice as appropriate.

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 A&E attendances. The practice provided sexual health support and contraception, maternity services and childhood immunisations. Data showed immunisation uptake rates were at or above average for Sheffield Clinical Commissioning Group (CCG). Appointments were available outside of school hours and the premises were suitable for children and babies. The practice told us all children under the age of two years had access to same day appointments.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The practice had extended hours, including appointments being available until 8pm once a week, to facilitate attendance for patients who could not attend appointments during normal surgery hours. There was a full range of health promotion and screening programmes that reflected the needs of this population group.

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.

The practice advised vulnerable people how to access various support groups and voluntary organisations. It regularly worked with multidisciplinary teams in the case management of vulnerable people. For example, CSWs, SOAR and health visitors. The practice accepted and registered patients from anywhere within the Sheffield area; including those who were of no fixed abode.

Staff knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. 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. The GPs actively screened patients for dementia and maintained a list of those diagnosed. The practice also supported a local residential care home which had a high number of patients who had dementia. All patients with a diagnosis of dementia also had care plans in situ. The practice informed patients how to access various support groups and voluntary organisations. For example, Insight (a local talking therapy service) and Improving Access to Psychological Therapies (IAPT).

Summary of findings

What people who use the service say

We received 21 CQC comment cards where patients shared their views and experiences of the service they received from the practice. We also spoke with eight patients on the day of our inspection. All the comments on the cards were positive and complimentary about the practice and the staff. Patients we spoke with told us the clinicians listened to them, explained treatments and involved them in decisions about their care. They told us they were treated with dignity and respect and staff were polite and friendly.

The majority of patients were complimentary about the appointment system and told us they often received an appointment on the same day as their request. Although they may sometimes have to wait to see a doctor of their choice. We looked at the National Patient Survey (January 2015), which had sent out 444 questionnaires and received 92 responses (21% completion rate). Eighty two per cent of respondents said they usually got to see/ speak with their preferred GP. This was significantly higher than the local CCG average of 58%.

The practice had made numerous attempts to form a Patient Participation Group (PPG), unfortunately there had been no uptake from their patients. They had undertaken their own patient survey and acted on comments from this. For example, some comments stated a particular GP did not start their surgery until up to 30 minutes after the first appointment time. It was found the GP was performing some of their administrative tasks, such as checking blood results and prescription requests, before starting their surgery. The GP had taken note of the comments and subsequently changed the times when they undertook their administrative tasks, to enable them to start on time.

Areas for improvement

Action the service SHOULD take to improve

- Ensure training records are up to date, to enable the practice to accurately monitor review dates.
- Ensure all clinical staff have a good understanding of Gillick competency assessments of children and young people.

Dr Dilip Chatterjee

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Dilip Chatterjee

Dr Dilip Chatterjee operates from Dunninc Road Surgery in a socially deprived area of Sheffield, which has a high level of unemployment and social housing. Many residents are of British Minority Ethnic (BME) origin and include people of Asian, African, Chinese and Eastern European ethnicity.

The practice provides Personal Medical Services (PMS) for a population of 3100 patients under a contract with NHS England. They are registered to provide the following regulated activities: treatment of disease, disorder or injury; family planning; maternity and midwifery services; diagnostic and screening procedures.

The practice has one male GP and one salaried male GP. In addition, there are two female practice nurses and a phlebotomist. The clinical team are supported by a practice manager and a team of experienced administration and reception staff.

The practice opening times are Monday to Friday 8am to 6pm, with the exception of Thursdays when the practice closes at 1pm. There are extended hours on Tuesday evenings from 6.30 to 8pm. Patients can access the appointment system at reception, by telephone or online via the practice website. Some appointments are pre-bookable and others are bookable on the day. A duty doctor is available each day to see or advise patients who need to be dealt with as emergencies. When the practice is closed, out-of-hours cover for emergencies is provided by NHS 111 and Care Direct.

Dr Dilip Chatterjee has worked at the practice for over 25 years and had a good understanding and working knowledge of the registered patients. A high proportion of patients have been with the practice since Dr Chatterjee started, including different generations of patients within families.

Why we carried out this inspection

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

Please note that 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 local area team and Sheffield Clinical Commissioning Group, to share what they knew.

Detailed findings

We carried out an announced inspection visit at Dr Dilip Chatterjee's practice based at Dunninc Road Surgery on the 6 May 2015. During our visit we spoke with a range of staff, including two GPs, the practice manager, a practice nurse and a receptionist. We also spoke with eight patients who used the service.

We observed communication and interactions between staff and patients, both face to face and on the telephone within the reception area. We reviewed 21 CQC comment cards where patients had shared their views and experiences of the practice. We also reviewed documents relating to the management of the practice.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included reported incidents, national patient safety alerts, clinical audits, comments and complaints received from patients.

The practice manager told us they would print off all national patient safety and medical alerts and disseminate them to staff. Upon reading them staff would sign them and return to the practice manager.

The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. They informed us incidents and complaints were raised and discussed at the practice and staff meetings.

Learning and improvement from safety incidents

The practice had systems in place for how they reported, recorded and monitored significant events, incidents and accidents. The practice manager gave us an example and showed us the system they used to manage and monitor incidents and the procedure for reporting these. The GPs and practice nurse also gave us examples of reported incidents, the actions the practice had taken and the learning points. For example, a specific form had not been completed prior to a death certificate being issued. The error had been picked up, an apology given to all concerned and practice procedures were amended to prevent a reoccurrence.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and adults whose circumstances may make them vulnerable. Staff we spoke with were aware of their responsibilities and 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 and procedures and the contact details of relevant agencies were available and easily accessible for all staff.

The practice had designated leads for safeguarding children and adults, who had completed level 3 safeguarding training. However, when we looked at training records it was not clear whether the administration/ reception staff were up to date in both children's and adults safeguarding. All staff we spoke with were aware of who the lead was, what they would do if they encountered a safeguarding concern and who to speak to in the practice. The practice manager informed us of the forthcoming date for safeguarding training which had been booked for all members of staff to attend.

There was a system in place to highlight vulnerable patients on the practice's electronic record. The practice held a monthly meeting with other health 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 in place and a poster displayed in the reception area alerted patients to the availability of a chaperone if required. (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.) Both nursing and reception staff had been trained to be a chaperone and could explain what their roles and responsibilities were.

Medicines management

We checked medicines stored in the treatment rooms and found they were stored securely and were only accessible to authorised staff. We checked the refrigerators where vaccines were stored. Staff told us they checked the refrigerator temperature on a daily basis. We saw evidence of daily records being kept which were dated, had the temperature recorded and signed by the member of staff who had undertaken the checks. We were told vaccines were checked for expiry dates on a monthly basis and disposed of in line with the practice protocol. We looked at a selection of vaccines and found they were within their expiry date. Expired and unwanted medicines were disposed of in line with waste regulations.

There was a repeat prescribing protocol in place. Requests for repeat prescriptions were taken in person at the reception desk, by post or over the internet. Administration/reception staff told us the checks they undertook prior to a prescription being dispensed. For example, name, address, date of birth of the patient and the medication being requested. All prescriptions were

reviewed and signed by a GP before they were issued. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The data from Sheffield Clinical Commissioning Group (CCG) which related to the practice's performance for antibiotic prescribing showed them to be comparable to local practices.

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.

An infection prevention and control (IPC) policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Personal protective equipment including disposable gloves and aprons were available for staff to use. Hand washing sinks with hand soap, antibacterial gel and hand towel dispensers were available in treatment rooms. Sharps bins were appropriately located and labelled. The practice had access to spillage kits and staff told us how they would respond to blood and body fluid spillages in accordance with current guidance.

A practice nurse was the lead for IPC. They told us it was their role to deliver IPC training awareness to other practice staff, manage any concerns and undertake regular IPC audits. We saw evidence they had received appropriate training and of audits which had been undertaken.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us a schedule was 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

The practice had a recruitment policy setting out standards it followed when recruiting clinical and non-clinical staff. We looked at three staff files and confirmed pre-employment checks were in place in line with the practice policy. For example, proof of identification, references and qualifications. The practice manager informed us they had arranged for all staff to have up to date Disclosure and Barring Service (DBS) checks, as all staff had been employed by the practice for many years. We have since seen evidence these have all been undertaken.

Staff told us about the arrangements for planning and monitoring the number and mix of staff required by the practice to meet the needs of patients. 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.

All non-clinical staff were part time and there was an arrangement in place for them to cover each other's annual leave and sickness. We were informed when the practice nurses were on annual leave the GPs will usually see patients if urgent. Locums were used when the GPs were on annual leave.

Monitoring safety and responding to risk

The practice looked at safety incidents and any concerns raised and identified how they could have been avoided. They also reported to external bodies such as NHS England and Sheffield CCG in a timely manner.

The practice had arrangements in place for how they monitored safety and responded to changes in risk to keep patients safe. A health and safety policy was in place which set out the steps to take to protect staff and patients from the risk of harm or accidents.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Emergency equipment was available and included access to oxygen and an automated external defibrillator (used to attempt to restart a person's hear in an emergency). Members of staff stated they knew the location of this equipment and how to use it. Records showed all staff had received training in basic life support.

Emergency medicines were available in a secure area of the practice. Staff told us equipment and emergency

Good

Are services safe?

medicines were checked on a daily basis and we saw records which confirmed this. We checked the equipment and medicines at the time of inspection and found all medicines were in date and the equipment was fit for use.

A business continuity plan was in place to deal with a range of emergencies that 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, loss of premises and loss of telephone systems. There was an electronic copy available on the practice computer system. A hard copy was also available in the practice and the practice manager kept a copy at home. There was a buddy system in place with a neighbouring GP practice should the telephone or computer systems become incapacitated or should a temporary loss of premises occur.

There were arrangements in place to protect patients and staff from harm in the event of a fire. For example, fire equipment checks, designated fire marshals and annual fire drills. All staff had received fire safety training.

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 weekly practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients care needs were discussed and required actions agreed.

The practice had registers for patients who had a long term conditions or required palliative care. Patients had their condition reviewed and monitored using standardised local and national guidelines. We were shown templates the clinicians used to manage conditions such as asthma, diabetes and hypertension (raised blood pressure).

The nursing staff we spoke with told us they used personalised self-care management plans with patients as appropriate, raised awareness of health promotion and referred/signposted to other services when required. The practice nurse told us how they supported newly diagnosed diabetic patients and referred to other services, such as podiatry and DESMOND; which was a local diabetic education programme.

We saw patients were appropriately referred to secondary and community care services. The clinical staff we spoke with could clearly outline the rationale for their treatment approaches.

The practice had achieved and implemented the Gold Standards Framework for end of life care. It had a register of patients who required palliative care. Regular meetings to discuss these patients' care needs were held with other appropriate health professionals, such as members of the district nursing team and palliative care nurses.

There were systems in place to identify and monitor the health of vulnerable groups of patients. We were told patients who had learning disabilities were given longer appointments, annual reviews were undertaken and consent was documented.

Interviews with staff showed the culture of the practice was that patients were cared for and treated based on need. The practice took into account a patient's age, gender race and culture as appropriate and avoided any discriminatory practises.

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, how they scheduled clinical reviews, 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. (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.) The practice was at or above average for many of the QOF domains, particularly in depression, epilepsy and palliative care.

The practice had a palliative care register and held regular multidisciplinary team meetings to discuss the care and support of patients. The practice had achieved 100% QOF points in this area.

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 were provided with summaries of six clinical audits which had been completed in the last twelve months. After each audit, actions had been identified and changes to treatment or care had been made. Where appropriate a repeat audit had been scheduled to ensure outcomes for patients had improved. For example, an original audit of breast screening had identified the uptake was below the national average. As a result the practice made an active effort to improve uptake by either speaking to eligible patients on the telephone or by raising awareness during consultation. The repeated audit had showed a 20% increase in uptake.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

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 fire safety.

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

Practice nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. For example, cervical cytology and diabetes management. The practice nurses were registered with the Nursing and Midwifery Council (NMC). To maintain registration they had to complete regular training and update their skills. The nurse we spoke with confirmed their professional development was up to date and they had received training necessary for their role. The practice manager told us the procedure for how they checked all clinical registrations.

Staff had received annual appraisals, with the exception of the practice manager. Learning needs had been identified and action plans documented. We were informed at the time of the inspection procedures would be put in place to ensure the practice manager had an annual appraisal and a personal development plan.

Staff told us they felt supported in their role and confident they could raise any issues with the practice manager or the GPs.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those patients who had complex needs. It received blood test results, X-ray results, letters and discharge summaries from other services, such as hospitals and out-of-hours services (OOHs), both electronically and by post. All staff we spoke with understood their roles and responsibilities when processing the information. There were systems in place for these to be reviewed and acted upon where necessary by clinical staff.

The practice held monthly multidisciplinary team (MDT) meetings to discuss the needs of palliative care patients. These meetings were attended by other health professionals, for example palliative care nurses and members of the district nursing team. Although the practice informed us there had been issues regarding regular attendance of district nursing staff due to considerable changes which had occurred within that service. Messages and information were currently conveyed to and from that service either by a message/ communication book or by telephone. The practice had identified the issues with both the district nursing service lead and Sheffield CCG.

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 (OOH) provider to enable patient data to be shared in a secure and timely manner. We were told information regarding patients who had complex health conditions was faxed securely to the OOH provider. For example, those who had advanced dementia, severe chronic obstructive pulmonary disease (COPD), were on an end of life care pathway and/or had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place. This was to ensure continuity of care and avoid any unnecessary distress to patients.

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

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

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 and Children Acts 1989 and 2004, although we could not find evidence they had received training in this area. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff told us they spent time on how they discussed treatment options and plans

Good

Are services effective?

(for example, treatment is effective)

with patients and were aware of consent procedures. They explained discussions were held with patients to obtain their consent prior to treatment. They were aware of how to access advocacy services.

We were informed how clinicians supported patients, who had a learning disability or mental capacity issues, to make decisions through the use of care plans.

Some of the clinical staff we spoke with demonstrated a clear understanding of Gillick competency assessment, whilst others had a limited understanding. These assessments were used to check whether a child under 16 had the maturity and understanding to make their own decisions about their treatment.

Health promotion and prevention

All new patients were invited for an appointment with a GP for a health check. This was to ensure any existing health issues or medication requirements were identified and managed appropriately.

The practice was involved with national breast, bowel and cervical cytology screening programmes. Follow up of non-attenders was undertaken by the practice. The practice's performance for cervical smear uptake was similar to other practices in the area.

They offered a full range of immunisations for children, flu vaccinations and travel vaccinations in line with current national guidance. Data showed childhood immunisation rates for the practice were at or above average for Sheffield Clinical Commissioning Group (CCG).

All patients over 75 years of age had a named GP. Patients who had a long term condition were invited for a health and medication review. Systems were in place to refer or signpost patients to other sources of support, for example smoking cessation or weight management clinics. With their consent, patients who had social issues were referred to the local community support worker or a local community organisation, SOAR, who offered counselling services and advice on benefit support as appropriate.

There was evidence of health promotion literature available in the reception area and the practice leaflet. The practice website provided health promotion and prevention advice and had links to various other health websites, for example NHS Choices.

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 from the National Patient Survey (January 2015), where from a sample of 444 questionnaires, 92 (21%) responses were received. The survey showed 90% of respondents said the GP treated them with care and concern and 97% said the nurse was good at listening to them. These were all above average for the CCG (86% and 92% respectively).

We received 21 CQC comment cards to tell us what they thought about the practice, which were all positive about the service they experienced. The majority of comments said staff were helpful and professional and as patients they felt listened to and respected.

We also spoke with eight 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. Some of the patients told us they had specifically moved to the practice as they had heard positive comments and felt they had received poor care at their previous practice in comparison.

We observed reception staff were courteous and spoke respectfully to patients. They listened to patients and provided information and support when needed. The staff we spoke with told us they were always careful about what questions they asked patients at the reception desk and they were aware of the need to maintain confidentiality.

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.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice good in these areas. For example, 83% of respondents said the GP involved them in decisions about their care; which was comparable to other local GP practices.

The patients we spoke with on the day or our inspection told us health issues were discussed with them in a way they could understand. They felt involved in decisions made about their care and treatment. They told us they felt listened to and had enough time during a consultation to make an informed decision about the choice of treatment they wished to receive.

Clinical staff told us written care plans were undertaken in conjunction with patients who had a long term condition, these included self-management plans. For example, patients who had asthma were given information of when to adjust their medication dependent on their symptoms.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with on the day of our inspection and the CQC comment cards we received highlighted staff were caring and provided support when needed. Notices in the patient waiting area and on the practice website provided information on how to access a number of support groups and organisations. For example, written information was available for carers to ensure they understood the various avenues of support available to them.

A practice nurse told us how they undertook PHQ9 questionnaires (an assessment tool to identify the possibility of depression) with patients and carers who may display or describe symptoms of anxiety or depression. The results of these would be discussed with the individual person and the GP. With the consent of the patient a referral would be made to the Improving Access to Psychological Therapies (IAPT) service. They also signposted patients to a local voluntary organisation who could provide support with emotional issues.

The clinicians we spoke with appeared to have in depth knowledge of their patients and carers and had a good understanding of their holistic care needs. Patients we spoke with also commented on how they felt cared for and told us the doctors often asked about their general health and well-being and that of their close family members/ carers.

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 Clinical Commissioning Group (CCG) and other agencies to discuss the needs of patients and service improvements. We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice provided a service for all age and population groups, which included the ethnic and cultural diversity of patients. We found the GPs were familiar with the individual needs of patients and the impact of their socio-economic environment.

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 monthly multidisciplinary meetings to ensure practitioners responded appropriately to the care needs of those patients.

Staff understood the lifestyle risk factors which affect some groups of patients within the practice population. We saw the practice provided a range of services and clinics where the aim was to help particular groups of patients to improve their health. For example, the practice provided patients with access to smoking cessation programmes and advice on weight and diet.

Tackling inequity and promoting equality

The practice had recognised the needs of the different population groups in the planning of its services. The practice had systems in place which alerted staff to patients with specific needs or who may be at risk.

There was disabled access to the building and all patient areas and consulting rooms were on the ground floor. The practice had recently been refurbished and the patient reception area adapted to ensure there was sufficient access for wheelchairs or prams.

We were informed there was ethnic diversity within their patient population, with some patients who did not have English as their first language. Staff told us how translation services could be accessed using language line (a telephone based translation system) or through a Sheffield translation organisation known as SCAIS.

Sign language services were accessible for those patients who may have hearing impairments. There was also information available in larger print or in pictorial form.

Access to the service

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the National Patient Survey. This indicated patients were generally satisfied with the appointments system at the practice. For example, 82% of respondents found it easy to get through to the practice by telephone, which was higher than the national average of 75%. The majority of patients we spoke with said they found it easy to get an appointment but may have to wait longer to see a GP of their choice. At the time of our inspection the next available pre-bookable appointment was within 48 hours.

Information regarding the practice opening times and how to make appointments was available in the reception area, the practice leaflet and on the website. Patients could book appointments by telephone, online or in person at the reception. Some appointments were pre-bookable and some were allocated to be booked on the same day. Home visits were offered for patients who found it difficult to access the surgery. The practice told us all children under two years of age were seen on the same day as requested.

A duty doctor was on call each day to see or advise patients who needed to be dealt with as emergencies. Telephone slots were available at the end of each surgery, where patients could request a GP to ring them for health advice.

The practice offered a range of appointments between 8am and 6pm, with the exception of Thursdays when the practice closed at 1pm. There were extended hours on Tuesday evenings from 6.30 to 8pm.

Information was available in the practice and on their website regarding out of hours care provision when the practice was closed.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were

Good

Are services responsive to people's needs?

(for example, to feedback?)

in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

Patients we spoke with were aware of the process to follow if they wished to make a complaint. One of the patients told us they had previously made a complaint and the process the practice had followed. This had reflected the practice complaints procedure.

We looked at how complaints received by the practice in the last twelve months had been managed. The records showed complaints had been dealt with in line with the practice policy and in a timely way. Patients had received a response which detailed the outcomes of the investigations. We saw actions and learning from complaints were shared with staff. For example, a patient had raised a concern regarding a medicine being changed from a brand to a generic form. The practice had explained the rationale behind the decision, ensured the patient understood and was satisfied with the outcome.

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

Staff we spoke with told us the vision and values of the practice were to maintain provision of a good service which provided excellent care and promoted positive outcomes for its patients. They told us they delivered a professional family doctor service in a friendly, caring and efficient way. This was evidenced through patient comments.

Governance arrangements

The practice had management systems in place. They had policies to govern activity, which incorporated national guidance and legislation. These were easily accessible for staff.

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 regularly discussed at practice meetings.

The practice had arrangements to identify, record and manage risk. The practice manager showed us the risk log which addressed a wide range of potential issues. We saw the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, there were leads for infection prevention and control and safeguarding children and adults. The staff we spoke with all understood their roles and responsibilities and knew who to go to in the practice with any concerns.

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 and a 'no blame' culture was evident at the practice.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. All patient survey results and action plans were available on the practice website. The practice also participated in the friend and family test and information was available both in the practice and on their website.

The practice did not have an active patient participation group (PPG), despite making numerous attempts to encourage patients to form a group. We looked at the results of the annual patient survey and found actions had been undertaken to improve patient access to the appointment system. For example, they had increased the number of same day appointments being available.

Staff told us they were encouraged to raise any concerns or provide feedback. They felt involved and engaged in the practice to improve outcomes for both patients and staff.

Management lead through learning and improvement

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

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