Drs. Perkins, Taylor, Syam and Sreelatha

Quality Report

Drs. Perkins, Taylor, Syam and Sreelatha
Stuart Road Surgery
Stuart Road
Pontefract
West Yorkshire
WF8 4PQ
Tel: 01977703437
Website: www.stuartroadsurgery.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.

Contents

Summary of findings

Overall summary

The practice is registered with CQC to provide the following regulated activities:

Diagnostic and screening procedures

Family planning

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

We spoke with 13 patients and reviewed 40 CQC comment cards which were completed by patients on the day of the inspection. The majority of the feedback we received was positive. Patients said they were treated with dignity, empathy and respect.

Some aspects of the service are safe. Appropriate arrangements for managing safeguarding are in place. Most areas of the practice are clean. Medicines are mostly well managed. Disclosure and barring checks (DBS) are not always carried out before employment commences. We have asked the provider to address these issues.

Some aspects of the service are effective.

Patients told us they receive a caring service and are treated with dignity and respect.

Some aspects of the service are responsive. The practice has an active patient participation group (PPG) in place, actively seeks patient feedback and is responsive to it. However, no records are available to show complaints have been investigated and by whom.

Some aspects of the service are not well led. Leadership roles and responsibilities were not clear, there were few systems in place for monitoring quality and there was a lack of staff engagement.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Some aspects of the service were safe. Appropriate arrangements for managing safeguarding were in place. Medicines were mostly well managed. Most of the practice was clean. Significant events, incidents and complaints were investigated and reflected on by the staff; resulting in changes at the practice. However there was a lack of systems in place to monitor patient and staff safety, which would enable the practice to identify trends in incidents, safety issues, performance issues, and to record learning. The practice did not have clear systems in place to manage and monitor risks to patients, staff and visitors to the practice.

Disclosure and barring checks (DBS) were not always carried out before employment commenced. We have asked the provider to address these issues.

Are services effective?

Some aspects of the service were effective. Care and treatment was being considered in line with current published best practice. Patients' needs were met and referrals to secondary hospital care were made in a timely manner. Plans for improving the service were not always in place and there were limited records to show how clinical audits and other monitoring systems were being used to monitor the quality of the service at the practice. Staff received annual appraisals. Clinical supervision was not used for nursing staff; to assess their performance and overall delivery of appropriate treatment.

Are services caring?

The service was caring. The CQC comment cards completed by patients, and the patients we spoke with were all complimentary about the care they received at the practice. Patients told us they were treated with dignity, empathy and respect. We also found patients were involved in decisions about their care and treatment.

Are services responsive to people's needs?

Some aspects of the service were responsive to people's needs. The practice proactively sought feedback from patients in a variety of ways and took action to address issues raised. A range of clinics and initiatives took place at the practice. Patients could access the service in a range of ways, although patients were concerned about

Summary of findings

the delay in getting appointments in advance. Patient's complaints were responded to although no records relating to the complaints investigation were available and no information on how to complain was displayed within the practice.	
Are services well-led? Some aspects of the service were not well led and there is scope to improve at the practice. Clear and planned governance structures were not in place. No risk management processes or strategies were used to monitor and improve the quality of service provided.	

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people
The service had adequate provision to ensure care for older people was safe, caring, effective and responsive. All patients aged 75 and over were allocated a named GP.

People with long-term conditions
The service had adequate provision to ensure care for people with long term conditions was safe, caring, effective and responsive. Registers and care plans for people with long term conditions were in place. A range of clinics such as asthma and diabetes were also made available to people.

Mothers, babies, children and young people
The service had adequate provision to ensure care for mothers, babies and young people was safe, caring, effective and responsive. The practice had well established input from health visitors. Clinics were made available for mothers and babies and childhood immunisation rates were high. The practice invited all patients for a health check when they reached the age of 16.

The working-age population and those recently retired
The service had adequate provision to ensure care for the working-age population and those recently retired was safe, caring, responsive and effective. Extended opening hours were available on Saturday mornings to improve access for working age adults. Repeat prescriptions and appointments could be arranged by telephone or on-line via the practice website. All patients between the age of 40 and 74 were offered a health check.

People in vulnerable circumstances who may have poor access to primary care
There was adequate provision to ensure care for people in vulnerable circumstances who may have poor access to primary care. Systems were in place at the practice to identify to staff patients who were vulnerable. All staff had received training in safeguarding and had made timely and appropriate referrals to other parties when they had concerns about vulnerable patients.

People experiencing poor mental health
There was adequate provision to ensure that care for people experiencing a mental health problem was safe, caring, responsive and effective. The practice had access to professional support such as the local mental health team and referrals were made for people

Summary of findings

experiencing mental health problems. The practice had a lead GP for mental health. However, the practice did not have a plan in place to improve their performance on undertaking physical health checks for people with severe mental health impairment.	

Summary of findings

What people who use the service say

We spoke with 13 patients and reviewed 40 CQC comment cards completed by patients on the day of the inspection. All the feedback we received was positive. Patients said they were treated with dignity, empathy and respect. We were also told by some patients that they had been supported during times of bereavement and were complimentary about the compassion and empathy shown towards them.

Patients told us the practice was always clean.

Some of the patients we spoke with told us how they felt fully involved in decisions about their care and treatment. They said they were provided with information to enable them to make their own decisions. They confirmed their consent was always obtained before any examinations were carried out.

We spoke with three members of the Patient Participation Group (PPG). They told us they felt their views were taken into account and they were involved in decisions about how to improve the service.

Patients reported no issues or concerns about being able to obtain a same day urgent appointment as additional appointments had been made available each day as part of an initiative to try and reduce accident and emergency attendances. However, 11 of the 53 people we spoke with or received comments from raised concerns about the length of time they had to wait for a pre-bookable appointment; up to 14 days in some cases.

Areas for improvement

Action the service MUST take to improve

The practice recruitment policy was not always followed. Disclosure and Barring Service (DBS) checks were not always completed before employment commenced.

The practice did not have systems in place to regularly monitor the quality of the service being provided. These included:

- Lack of systems in place to monitor patient and staff safety, which would enable the practice to identify trends in incidents, safety issues, performance issues, and to record learning.
- Plans for improving the service were not always in place and there were limited records to show how clinical audits and other monitoring systems were being used to monitor the quality of the service at the practice.
- Some audits did not show how issues would be addressed, by when and by whom.
- Clinical supervision was not used for nursing staff; to assess their performance and overall delivery of appropriate treatment.
- Clear and planned governance structures were not in place.
- No risk management processes or strategies were used to monitor and improve the quality of service provided.
- Lack of systems for monitoring staff training and recording staff induction.

Action the service SHOULD take to improve

The practice did not keep records of any meetings/ discussions held at the practice, for example clinical, multi-disciplinary, safeguarding or target meetings.

The practice did not have records in place to show how complaints were investigated and by whom.

The practice was unable to show how they were planning to address the remaining outstanding infection control issues and by when.

Outstanding practice

The practice invited all patients for a health check when they reached the age of 16.

Drs. Perkins, Taylor, Syam and Sreelatha

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. Other team members included a second CQC inspector, a practice manager and an expert by experience.

Background to Drs. Perkins, Taylor, Syam and Sreelatha

Stuart Road Surgery is situated in the centre of Pontefract and provides primary medical services to patients living in Pontefract and the surrounding areas. The practice has five GPs, one nurse manager, two nurse practitioners, one advanced nurse practitioner, two healthcare assistants, a practice manager and a range of administration staff. At the time of the inspection the practice was providing a service to 8480 patients. The practice opens from 8.00am to 6.30pm Monday to Friday and from 8.00am to 12.15pm on Saturday mornings. The practice treats patients of all ages and provides a range of medical services.

The practice is part of Wakefield NHS Clinical Commissioning Group (CCG). The largest population group for the practice is 0 – 15 years olds at 16.5% and the lowest being 85+ at 2%. Wakefield is the 77th most deprived area out of 326 local authorities. Deprivation is higher than average.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider has not been inspected before and that is why we included them.

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

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

Before visiting, we reviewed a range of information about the service and asked other organisations to share what

Detailed findings

they knew about the service. We carried out an announced visit on 9 July 2014. During our visit we spoke with a range of staff including GP's, the practice manager, nursing and administration staff. We spoke with patients who used the service. We reviewed a variety of documents used by the practice in relation to the management of the service. We reviewed CQC comment cards where patients shared their views and experiences of the service.

Are services safe?

Our findings

Some aspects of the service were safe. Appropriate arrangements for managing safeguarding were in place. Medicines were mostly well managed and most of the practice was clean. Significant events, incidents and complaints were investigated and reflected on by the staff; resulting in changes at the practice. However there was a lack of systems in place to monitor patient and staff safety, which would enable the practice to identify trends in incidents, safety issues, performance issues, and to record learning. The practice did not have clear systems in place to manage and monitor risks to patients, staff and visitors safety.

We found disclosure and barring checks (DBS) were not always carried out before employment commenced. We have asked the provider to address these issues.

Safe patient care

The practice had some systems in place for monitoring patient safety. Incidents, accidents and complaints were recorded. An incident reporting policy was in place at the practice and staff confirmed they were aware of how to report incidents. They told us how incidents were investigated and learning shared with them at staff meetings. We were told that GPs discussed incidents at their weekly meetings; however there were no records available to confirm this.

Staff were of aware of latest best practice guidelines and they incorporated this into their day to day practices. Concerns relating to individual patients were passed on to the relevant people in a timely way. For example staff had contacted social services when they were concerned about an elderly person who visited the practice.

Learning from incidents

We saw some evidence that significant events, incidents and complaints were investigated and reflected on by the staff. For example, action had been taken to amend practice following an incident relating to the administration of an expired vaccine. GPs told us significant event audits were included in their GP portfolio and were used to reflect on their practice and to identify any training or policy changes required for them and the practice. For example an audit on minor surgery had been completed on two occasions.

Safety alerts were checked and acted upon by clinical staff as soon as they were notified. For example, a recent alert regarding the use of a certain painkiller and guidelines for patients with arterial fibrillation had been acted on.

There were no systems in place to analyse incidents, significant events or complaints over a period of time therefore the practice was unable to identify trends in incidents that occurred and monitor if improvement had taken place.

Safeguarding

The practice had a safeguarding policy in place; although one GP was not aware of this. The staff we spoke with were clear about their role in safeguarding and were able to describe the different types of abuse and what action they would take if they were concerned about anything. Staff described incidents when they had raised safeguarding concerns and worked with other health care professionals and other partners such as social services, housing and landlords. For example concerns were raised with the health visitor when a child did not turn up for an appointment at the practice and they had previously had high accident and emergency (A&E) attendances. Alerts were put onto the patient's electronic record when safeguarding concerns were raised.

There were no formal arrangements or meetings that GPs attended and there were no practice safeguarding meetings when there were safeguarding concerns. This was reliant on informal communications between the practice and the HV.

A practice lead for safeguarding was in place. They had completed training to support them in carrying out their role, as recommended by professional bodies safeguarding guidance. Other staff had completed training to a suitable level in safeguarding children but not for adults.

Monitoring safety and responding to risk

The practice did not have clear systems in place to manage and monitor risks to patients, staff and visitors safety when they were at the practice.

The health and safety policy was out of date. There were no environmental risk assessments in place or arrangements for legionella testing. We were told that staff

who used computers had not completed mandatory display screen equipment (DSE) assessments as required under The Health and Safety (Display Screen Equipment) Regulations 1992.

Medicines management

There were systems and policies in place for the management of medicines. Appropriate arrangements for managing repeat prescriptions were in place. The practice worked closely with the local pharmacist and pharmacy technician for support and advice. Staff described the arrangements for managing patient's medication when they were discharged from hospital.

The practice did not hold stocks of controlled drugs (these are medicines which require extra administration checks to ensure safety). Emergency drugs and vaccines were stored and monitored which ensured patients received medicines that were in date and fit to use. Vaccines were securely stored, in date and stock rotation evident so vaccines were used in date order. We found one glucagon injection that was out of date and some of the vaccine boxes were wet. The fridge temperatures were within the required range for the safe use of the vaccines and were checked regularly by staff.

Arrangements were in place for the safe management and storage of prescription pads. Repeat prescriptions were stored securely. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them. They were also able to describe the additional checks required when giving out prescriptions for controlled drugs. The doctor's bags were checked and medicines found to be in date. Systems were in place for checking the bags although not all GP's were aware of this.

Cleanliness and infection control

Patients told us the practice was always clean. We looked in the waiting area, corridors, two GP rooms and four treatment rooms. The majority of the rooms and equipment were clean and tidy. The flooring in some of the rooms was stained and dirty and a badly stained sink was observed in one GP room. Fabric covered seats were in use in the waiting rooms and in some of the clinical rooms; some of which were observed to be stained. When asked, staff were unclear what the arrangements were for them to be cleaned. Fabric privacy curtains were used throughout the practice. They were observed to be clean and we were told these were laundered annually with replacements being available if needed. Records to show a planned programme of cleaning for the curtains was available but not for chairs or carpets. Cleaning staff were employed from an external company. We saw that best practice guidelines for cleaning were being followed and monitoring was carried out to ensure procedures were being followed and standards maintained.

Sharps bins were available, appropriately stored and used. Bins with lids and foot pedals for the disposal of general and clinical waste were in place in most of the rooms. Special kits to be used in the event of a spillage of blood or body fluids were available and stored appropriately. Personal protective equipment (PPE) such as gloves and aprons were available and staff were seen wearing them throughout the day. Hand washing instructions and facilities were available in all the areas we looked at.

The practice had a comprehensive infection control policy in place; however this was not always followed. The policy stated staff should be trained in infection control annually, as recommended by the Royal College of Nursing (RCN), however the records showed staff last completed such training two years ago. However, the staff we spoke with were clear about their role and the measures they needed to take to prevent the spread of infection. Most staff knew who the infection control lead was at the practice. A named nurse was responsible for managing and monitoring immunisations, such as Hepatitis B, for staff working at the practice and records confirmed this.

Staff we spoke with told us that all equipment used for procedures such as smear tests and for minor surgery were disposable, which meant staff were not required to clean or sterilise any instruments which reduced the risk of infection for patients. Systems were in place for checking single use items used within the practice had not expired. All items examined were within date.

Two Infection control audits had been completed in 2013 at the practice and an action plan was put in place. Some issues had been addressed, however, the practice was unable to show how they were planning to address the remaining outstanding issues and by when. For example; the replacement of the hand operated taps and overflows in the sinks.

Staffing and recruitment

There was a policy in place for the safe recruitment of staff; although this was not always followed. We looked at five

staff files, two of which were for staff that had recently joined the practice. A range of pre-employment checks were carried out. Professional registrations with the relevant professional bodies for GPs (General Medical Council (GMC)) and for nurses (National Midwifery Council (NMC)) were carried out, as well as obtaining references, training details and employment history. However Disclosure and Barring Service (DBS) checks were not always completed before employment commenced. The DBS helps employers make safer recruitment decisions. It also prevents unsuitable people from working with vulnerable groups, including children, through its criminal record checking and barring functions. Pre-employment health checks were not done prior to appointment therefore the provider would not know if staff were physically and mentally fit and able to carry out their role.

Staff told us staffing levels were managed and adjusted to ensure there was enough staff to ensure patients received a safe level of care. A policy on managing staffing levels was in place at the practice. The policy detailed who was responsible for monitoring staffing levels and the minimum numbers of staff required in each group; such as GPs, nurses and administration staff. We were told that staffing levels were monitored and adjusted accordingly to ensure there was sufficient cover at the practice including the right skill mix. An additional member of the nursing team had recently been employed to help improve the service at the practice. When required, locums who were familiar with the service worked at the practice.

Dealing with Emergencies

A business continuity risk plan was in place to deal with a range of emergencies that may have impacted on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, unplanned sickness and access to the building. Other risks were detailed in a separate document which did not always state what action to take. For example there was no clear guidance on what to do in the event of a fire and we were told the last fire evacuation drill took place in 2008.

Emergency equipment such as defibrillators, oxygen, panic buttons and medicines were available and accessible for staff to use in an emergency. Records showed that equipment and medicines were checked regularly. We were told there were no arrangements in place for checking the oxygen levels in cylinders were at required levels. The staff we spoke with had a clear understanding of what they would do in the event of a medical emergency at the practice and records confirmed staff had received training in Cardio Pulmonary Resuscitation training.

Equipment

We looked at a range of equipment at the practice. Equipment had recently been portable appliance tested (PAT) and calibrated. No previous records were available and there was no evidence of a future plan for maintenance and servicing of equipment.

Nursing staff told us they had access to equipment such as a spirometry and blood pressure machines. Arrangements were in place for the health care assistant to check equipment on a monthly basis.

Are services effective?

(for example, treatment is effective)

Our findings

Some aspects of the service were effective. Care and treatment was being considered in line with current published best practice. Patients' needs were met and referrals to secondary care were made in a timely manner. Plans for improving the service were not always in place and there were limited records to show how clinical audits and other monitoring systems were being used to monitor the quality of the service at the practice. Staff received annual appraisals however clinical supervision was not used for nursing staff; to assess their performance and overall delivery of appropriate treatment.

Promoting best practice

The practice had a policy on sharing information such as National Institute of Health and Care Excellence (NICE) guidelines and safety alerts within the practice; although there was no evidence of formal systems to share the guidance with the relevant staff. Despite this, individual staff told us they kept up to date with new guidelines and best practice.

Staff we spoke with described how patients care was planned and reviewed on a regular basis to ensure they were receiving the most appropriate and up to date care. Staff described how they used best practice guidelines when patients attended the specialist clinics for conditions such as COPD and asthma. We were told that at a recent staff meeting a specialist attended to talk about a specific long term condition and the nursing staff were now considering if they could manage that long term condition in a better way.

Written guidance for managing test results was in place and staff were clear about their different roles and responsibilities for managing these. They described the arrangements in place to contact patients who did not attend the practice for a follow up appointment. We confirmed that arrangements were in place to ensure test results were followed up for locum staff who did not work at the practice on a regular basis.

Management, monitoring and improving outcomes for people

We found the practice had some formal mechanisms in place to monitor the performance of the practice. The practice provided us with some evidence that the team was making use of clinical audit tools to monitor their performance and improve outcomes for people. For example they had reviewed their referrals for patients with diabetes and reflection, learning and changes were evident. The practice had systems in place which supported GPs and other clinical staff to improve clinical outcomes for patients. The practice kept up to date registers of patients with long term conditions such as asthma and chronic heart disease. These were used to arrange annual health reviews.

The staff we spoke with discussed audits that had taken place and said they met within their own staff groups, for example the nurses met together, to reflect upon the outcomes being achieved and areas where this could be improved. The practice was proactive in assessing different patient groups to identify any potential health problems that may occur. For example, each child was invited to the practice for a health review on their 16th birthday. Despite this there was no plan for how they would monitor the uptake of these checks and the impact this had on patients. We found action had been taken in some areas where performance was low on the quality outcome framework (QOF); for example introducing an additional nurse practitioner to the practice. However we also found, through discussion with staff that there were no improvement plans in place for other areas that had been identified as low performance on the QOF, for example physical health checks for patients with severe mental health conditions.

The practice manager could describe areas that the practice was monitoring and initiatives the practice was involved in. Despite this there were no records or plans available to confirm this was happening.

We were told by GPs and the practice manager that areas for improvement or initiatives were discussed at weekly clinical meetings. However, there were no records to confirm this and there were no specific plans in place to manage these. For example there was no plan and a lack of understanding by some staff as to how the initiative for every patient over the age of 75 to have a named GP was managed. Staff were not aware of how many patients over 75 had already been allocated a named GP and the timescale for when this would be achieved. The practice manager told us about the new initiative for 2% of the most vulnerable of the population to have a care plan; although

Are services effective?

(for example, treatment is effective)

staff were unclear about what they had to achieve and by when. There were no plans of how these initiatives would be achieved which would enable the practice to monitor their performance in meeting the targets.

Staffing

The practice did not have a written procedure outlining how staff support would be provided in the practice. All the staff we spoke with confirmed they received an annual appraisal and we saw records to confirm this. The appraisal covered performance, duties, training and development, and long term development. Staff told us they felt supported by the GPs and their manager. They received appropriate support to enable them to carry out their job or develop into a new role. They said they felt confident in raising any issues. Although there was no formal clinical supervision process in place for the nursing staff they told us that they felt supported by the senior team and were able to raise issues at any time.

Staff confirmed they had completed an induction that was specific to the role they carried out; however there were no role specific induction records available to show staffs' competency had been assessed. We observed administration staff undertaking induction on the day of our inspection. The practice had in place a training record for staff; however this did not reflect the training that staff told us they had completed. We were unable to obtain a clear picture of what training staff had completed. We discussed training with the practice manager and they were unclear what was classed as mandatory training. Staff told us they could access training although time to complete training was an issue for some staff.

Working with other services

We were told that monthly multi-disciplinary meetings took place with palliative care nurses, district nurses, partners and the practice manager. We were unable to review any formal minutes of these meetings as they updated individual patient records following these discussions but did not keep minutes. We were told that nurses or salaried GP's did not attend these meetings unless capacity allowed or they were invited. The practice manager and nurses told us issues were discussed informally with district nurses or health visitors when they were in the practice and when the need arose.

We received feedback from the local CCG that the practice had an excellent working relationship with the link health visitor. We also heard how the practice worked with other partners such as the police and social services to share information. The practice received information through the computerised record system if their patients attended the emergency out of hour's doctors' service so care could be continued as required. The practice worked closely with the CCG to identify issues with referrals to secondary care at the hospital. Following this, work was undertaken to improve access to physiotherapy services for patients and reduce the need for hospital attendance.

Health, promotion and prevention

Arrangements to support patients to manage their health and well-being were in place. A range of screening programmes were offered, including preventative vaccinations, chronic disease management and smears. The CCG told us the practice had a good uptake of childhood immunisations. Health promotion information for patients was provided via the website and in the practice reception area.

All new patients completed a health questionnaire which looked at current and previous illnesses, including long term conditions, alcohol consumption, date of last cervical smear and mental health conditions. The questionnaire could be completed at the practice or on the website. Detailed information about registering at the practice was available on the website.

The practice was proactive in assessing some patients to identify any potential health problems that may occur. For example, patients between 40 and 74 were offered a health check and the practice website asked patients to complete a physical activity questionnaire.

The practice had identified patients who may need extra support in a wide range of areas; for example learning disabilities, dementia and palliative care. We were told the practice had started to gather information about people who were carers and this was seen to be part of the information requested when registering with the practice and/or when having a review.

Are services caring?

Our findings

The service was caring. The CQC comment cards completed by patients, and the patients we spoke with were all complimentary about the care they received at the practice. Patients told us they were treated with dignity, empathy and respect. We also found patients were involved in decisions about their care and treatment.

Respect, dignity, compassion and empathy

We spoke with 13 patients and reviewed 40 CQC comment cards completed by patients on the day of the inspection. All the feedback we received was positive. Patients said they were treated with dignity, empathy and respect. Some patients said they had been supported during times of bereavement and were complimentary about the compassion and empathy they experienced at the practice.

Staff were clear about their role in protecting a patient's dignity and treating them with respect. Some staff had completed training in equality and diversity. Staff also understood their role in ensuring patient confidentiality was maintained at all times; including ensuring patient information was not unduly disclosed. The practice had a confidentiality policy and information about confidentiality and the use of patient records was available on the practice website.

Staff were observed treating patients with dignity and respect when they booked in at reception. We observed conversations; in person or via the telephone were discreetly managed. Alterations had been carried out to the reception area to improve confidentiality. A room was made available for patients should they wish to discuss a matter in private outside of the reception area.

Consultations took place in rooms with an appropriate couch for examination and curtains to maintain privacy and dignity. The practice had a chaperone policy in place and information telling patients they could ask for a chaperone was displayed throughout the practice. Nursing staff acted as chaperones and administration staff only acted as chaperones if a nurse was not available. No formal chaperoning training had been undertaken by administration staff; however the policy stated that staff would only act as a chaperone if they understood their role and responsibilities.

Involvement in decisions and consent

Clinical staff were aware of what was required in relation to the requirements of the Mental Capacity Act 2005 and the Children Act 1989 and 2004. Capacity assessments and Gillick competency of children and young people, which check whether children and young people have the maturity to make decisions about their treatment, were an integral part of clinical staff practices. Staff provided examples which demonstrated their understanding of 'best interest' decision making for people who lacked capacity, for example vaccinations for children.

Patients we spoke with discussed how they felt fully involved in decisions about their care and treatment. They said they were provided with information to enable them to make their own decisions. They confirmed their consent was always sought and obtained before any examinations were conducted.

We spoke with three members of the PPG. They told us they felt their views were taken into account and for some issues; they were involved in decisions about how to improve the service offered at the practice. For example improving communication between the practice and patients by use of e-mail and text messaging.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Some aspects of the service were responsive to people's needs. The practice proactively sought feedback from patients in a variety of ways and took action to address issues raised. A range of clinics and initiatives took place at the practice. Patients could access the service in a range of ways, although patients were concerned about the delay in getting appointments in advance. Patient's complaints were responded to although no records relating to the complaints investigation were available and no information on how to complain displayed within the practice.

Responding to and meeting people's needs

The practice was accessible to patients with mobility difficulties as it was all on one level. There was a toilet facility which had enabled access and baby changing facilities. The waiting area was small and on the day of the inspection we observed a patient having to stand as there was insufficient seating. The practice had identified a number of areas relating to the facilities at the practice as issues in their risk plan. For example one issue related to the ease of accessibility through some of the doors as they were heavy and the practice manager told us they had put in place mitigating measures such as assisting people who needed help. However on the day of our inspection we observed a patient who had mobility problems struggling to open a toilet door after staff had asked them go in there to provide a urine specimen. The practice was exploring the possibility of moving to more suitable premises although there were no plans or a timescale for when this may be achieved.

Staff were knowledgeable about the availability of interpreter services for patients where English was their second language. Practice literature and information displayed within the practice was not available in other formats, for example braille, large print or other languages. There was no information available about the use of advocates and some staff were unclear about what this meant. Hearing loops were not installed at the practice which may make it harder for people with hearing difficulties to hear the staff talking to them, for example at reception. One staff member we spoke with told us they had not had any problems and would use written notes if necessary.

The practice had systems in place for contacting patients who failed to attend vaccination and screening programmes. They worked with other health providers to support patients to attend the practice. Patients' electronic records contained alerts to show that a patient may require a longer appointment, for example a person with multiple illnesses or a learning disability.

Appropriate arrangements were in place for managing patients test results. The system of choosing and booking secondary care hospital appointments took place at the practice and patients confirmed this. Some patients commented that they had been referred to another service by the GP in a timely way. No formal referral meetings took place at the practice between GPs, although an audit of referrals in areas such as orthopaedics had been carried out.

Out of hours information was displayed on the practice website and within the practice. Systems were in place at the practice for following up on patient out of hours attendance to determine whether a follow up appointment was needed. We were told that non-clinical staff determined whether a follow up appointment with the GP was needed; however there were no records to show that the practice monitored the decisions made by non-clinical staff.

Access to the service

Patients reported no issues or concerns about being able to obtain an urgent appointment on the same day. This was due to additional urgent appointment slots being made available each day as part of an initiative to try and reduce accident and emergency attendances. However, 11of the 53 people we spoke with or received comments from raised concerns about the length of time they had to wait for a pre-bookable appointment; up to 14 days in some cases. We heard telephone conversations to confirm this. The practice was working to address this issue and had put in place a range of measures to try and improve the waiting times. This included training nurses to carry out minor surgery, an on-line booking facility and GP/nurse telephone appointments. Arrangements were in place for staff to check whether calls to the reception were managed in a timely way.

The practice offered extended opening hours on a Saturday morning from 8.00am to 12:15pm. The practice offered

Are services responsive to people's needs?

(for example, to feedback?)

patients a range of ways they could access the service. This included using the telephone or internet to order repeat prescriptions, register as a new patient and book appointments.

Information was displayed on the practice website on what to do and who to contact in the event of an emergency when the practice was not open.

Concerns and complaints

The practice did not have a systematic approach to learning from concerns and complaints raised. The practice had a complaints procedure in place, although it did not detail the timescale within which the patient could expect the complaint to be responded to. Details of how to complain were available on the practice website although no information was displayed within the practice reception area.

We looked at the records of complaints received by the practice. We saw complaints were responded to and learning and reflection following the complaint was referred to in the response to the complainant; although there was no detail of what this learning and reflection was. There was no evidence of an investigation and learning from formal complaints being incorporated into learning overall.

The NHS Choices website allows patients to leave feedback on their experience of using the practice. The website showed that where negative comments had been posted, the practice had responded. However the response did not always appropriately address the issue or invite the patient to discuss the issue further, but referred to the latest statistics about satisfaction levels from the most recent patient survey.

The last meeting of the Patient Participation Group (PPG) showed issues from the last patient survey were considered and actions were put in place to address issues raised. For example improving communication via text messaging and e-mail. However there was no evidence of how the practice was analysing the impact of the changes introduced.

Are services well-led?

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

Our findings

There were some aspects of the service that were not well led and there is scope to improve at the practice. Clear and planned governance structures were not in place. No risk management processes or strategies were used to monitor and improve the quality of service provided.

Leadership and culture

The practice did not have a clear strategy to assist them to ensure that they delivered high quality care and that would enable them to identify potential risks to the quality of care in the practice.

The practice had identified leads for key areas such as clinical audit, infection prevention and control and safeguarding, however in some areas it was not evident how effective the lead's role was in ensuring that these areas were progressed. For example there was a list of audits that would be undertaken during 2014 but there were no records of how the audit would be completed, by when and by whom. From discussions with staff it appeared only one GP took a leadership role at the practice; with other GPs confirming they did not get involved in any management or QOF responsibilities. There were no clear action plans for some audits that had been completed, they did not identify who was responsible for actions, date for completion and if they had been completed.

Governance arrangements

The practice did not have in place a planned programme for monitoring all aspects of the service provided and for managing risks. It appeared only one GP took a leadership role at the practice. We found the impact of this to be inconsistent understanding of processes and policies by staff; poor oversight of clinical supervision arrangements; no action being taken to ensure staff were recruited correctly and a lack of team cohesion.

We were told no risk assessments had been undertaken of significant risks to reduce the potential harm to staff, patients and visitors.

The practice had submitted performance data to the CCG, although they had not submitted the Department of Health Information Governance Toolkit data which they were required to do. We were told they did not have a system to remind the practice that this needed to be completed.

Systems to monitor and improve quality and improvement

We found a lack of systems in place to monitor and improve the quality of the service.

Safety alerts were checked and acted upon by clinical staff as soon as they were notified. For example, a recent alert regarding the use of two specific drugs had resulted in the GPs reviewing and changing their prescribing practice. We saw some evidence that significant events, incidents and complaints were investigated and reflected on by the staff. GPs told us significant event audits were included in their portfolio and were used to reflect on their practice and identify any training or policy changes required for them and the practice. An example of this was an audit of the use of a certain medicine to help improve survival after a heart attack.

However, we found there were no systems in place to analyse incidents, significant events or complaints over a period of time to enable the practice to identify trends in incidents and performance issues and to record learning. The practice was aware of low performance figures on QOF, for example physical health checks for people with severe mental health problems, yet we were told there was no specific plan to improve this. Many of the audits we saw were in response to significant events on individual GP portfolios or initiatives or issues raised by external bodies, for example the CCG.

Patient experience and involvement

The practice had systems in place for gaining feedback from patients. An active PPG had been set up by the practice. A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided and, over time, commissioned by the practice.

We spoke with three members of the PPG. They told us they were satisfied with the way the PPG was run and that GPs attended the meetings. They told us they mostly felt listened too and provided examples of changes that had been implemented following feedback from patients. For example improved communication with patients and the availability of telephone appointments with GPs. A summary report of the activity of the PPG for 2013 – 2014 was available to view on the practice website.

Are services well-led?

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

The practice carried out a patient survey for 2013 – 2014 and had put an action plan in place. They also actively sought patient feedback on the practice website.

Staff engagement and involvement

Staff told us they could raise concerns and felt they were listened to. All staff told us they felt supported. The practice had a whistleblowing policy in place which supported staff to raise concerns with people outside of the practice.

The practice manager was involved in a range of meetings external to the practice including being a member of the Wakefield CCG. Staff told us they had regular staff meetings and a half day each month for training or larger group meetings. There were no minutes available from these meetings.

We found there were varied levels of staff engagement and involvement and we identified a lack of team cohesion. Staff we spoke with told us they did not have meetings where all the different staff groups, GPs, nurses and administration attended. Staff we spoke with told us that decisions affecting their staff group were made by other professionals without discussing it with them first.

Learning and improvement

We saw some evidence that learning and improvement took place at the practice. Staff described how improvements had been made following learning from incidents, audits and practice reflection. However, there were limited records to show that a planned approach to learning and improvement was in place. There were no central records of complaints, significant events or incidents that the provider could refer to, in order that they could monitor their long term improvement.

Staff told us they could access training. The practice website showed that the practice was closed one afternoon each month for training. Staff confirmed that they attended training and we saw certificates in individual staff files. However the practice did not have a central record of what training staff had completed and no systems for ensuring they knew when refresher training was due and if this had taken place. We saw examples where training was overdue.

Identification and management of risk

The practice did not have planned systems in place to identify, assess and manage risks related to the service. The practice's health and safety policy was out of date and there were no risk assessments in place for patients, staff or visitors to the practice.

There was a policy for the recording of incidents, accidents and significant events. We were told the results were discussed at meetings and if necessary changes were made to the practice's procedures and staff training. There were no records of the meetings available to confirm this.

We were told the practice carried out audits and checks to monitor the quality of services provided. We were provided with records of six clinical audits and six prescribing audits. Of the six clinical audits, only one was a completed audit cycle. We saw some reflection, learning and proposed changes in the records. Of the six prescribing audits, two were not audits and the others were not completed audit cycles. Some change of practice was noted but there was limited paperwork to support the audits.

Older people

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

Our findings

The service had adequate provision to ensure care for older people was safe, caring, effective and responsive. All patients aged 75 and over were allocated a named GP.

People with long term conditions

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

Our findings

The service had adequate provision to ensure care for people with long term conditions was safe, caring, effective and responsive. Registers and care plans for people with long term conditions were in place. A range of clinics such as asthma and diabetes were also made available to people.

Mothers, babies, children and young people

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

Our findings

The service had adequate provision to ensure care for mothers, babies and young people was safe, caring, effective and responsive. The practice had well established input from health visitors. Clinics were made available for mothers and babies and childhood immunisation rates were high. The practice invited all patients for a health check when they reached the age of 16.

Working age people (and those recently retired)

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

Our findings

The service had adequate provision to ensure care for the working-age population and those recently retired was safe, caring, responsive and effective. Extended opening hours until 6.30pm were available Monday to Friday and Saturday mornings to improve access for working age adults. Repeat prescriptions and appointments could be arranged by telephone or on-line via the practice website. All patients between the age of 40 and 74 were offered a health check.

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

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

Our findings

There was adequate provision to ensure care for people in vulnerable circumstances who may have poor access to primary care. Systems were in place at the practice to identify to staff patients who were vulnerable. All staff had received training in safeguarding and had made timely and appropriate referrals to other parties when they had concerns about vulnerable patients.

People experiencing poor mental health

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

Our findings

There was adequate provision to ensure that care for people experiencing a mental health problem was safe, caring, responsive and effective. The practice had access to professional support such as the local mental health team and referrals were made for people experiencing mental health problems. The practice had a lead GP for mental health. However, the practice did not have a plan in place to improve their performance on undertaking physical health checks for people with severe mental health impairment.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The practice did not operate effective recruitment procedures which ensured staff were fit to undertake their role.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The practice did not have suitable arrangements in place for assessing and monitoring the quality of service provision.**