City View Medical Practice

Quality Report

City View Medical Practice (Floor 1)
Beeston Hill Community Health Centre
123 Cemetery Road,
Beeston,
Leeds,
LS11 8LH
Tel: 0113 276 0717
Website: www.cityviewmedical.com

Date of inspection visit: 14/10/2014
Date of publication: 11/12/2014

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?	Outstanding
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice:

We carried out an announced inspection visit on 14 October 2014. The overall rating for the practice was good.

We found the practice to be good in the areas of safe, caring and effective and for the population groups it serves. In addition we rated the practice as outstanding with respect to its responsiveness to patient's needs.

Our key findings were as follows:

- Where incidents had been identified relating to safety, staff had been made aware of the outcome and action taken where appropriate, to keep people safe.
- All areas of the practice were visibly clean and where issues had been identified relating to infection control, action had been taken.
- People received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to ensure they were up to date with best practice.
- The service ensured people received accessible, individual care, whilst respecting their needs and wishes.
- We found there were positive working relationships between staff and other healthcare professionals involved in the delivery of service.

We saw areas of outstanding practice including:

- The practice actively supported the Patient Participation Group and the 'Practice Health Champions' who were volunteers. They work with the staff to find new ways to improve the service and help to meet the health needs of patients and the wider community.

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 safe. There were standard operating procedures and local procedures in place to ensure any risks to patient's health and wellbeing was minimised and managed appropriately. The practice learned from incidents and took action to prevent a recurrence. Medicines were stored and managed safely. The practice building was clean and well maintained and systems were in place to oversee the safety of the building.

Are services effective?

Good

The practice is effective. Patients' received care and treatment in line with recognised best practice guidelines. Their needs were consistently met and referrals to secondary care were made in a timely manner. The practice worked collaboratively with other agencies to improve the service for people.

Are services caring?

Good

The practice is caring. The patients who responded to Care Quality Commission (CQC) comment cards and those we spoke with during our inspection, gave positive feedback about the practice. Patients described to us how they were included in all care and treatment decisions and they were very complimentary about the care and support they received.

Are services responsive to people's needs?

Outstanding

The practice is responsive. We judged this area to be outstanding in the way they proactively supported the Patient Participation Group (PPG) and the 'Practice Health Champions' (PHC) volunteers in order to improve the service and help meet the health needs of patients and the wider community. The practice had listened to what people said and reviewed the appointment system to ensure more available appointments.

Records showed that staff responded appropriately and learned lessons when things did not go as well as expected or according to plan. There was a complaints policy available in the practice and staff knew the procedure to follow should someone want to complain.

Summary of findings

Are services well-led?

The practice is well led. The practice was meeting people's needs in providing a service where the GPs and nurses had specific lead responsibility for areas of care, for example, safeguarding adults and children. Patients and staff felt valued and a proactive approach was taken to involve and seek feedback from patients and staff.

Good 

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 made provision to ensure care for older people was safe, caring, responsive and effective. All patients over 75 years had a named GP. There were systems in place to ensure that older people had regular health checks and timely referrals were made to secondary (hospital) care. Good information was available to carers. Older people were represented on the Patient Participation Group (PPG).

People with long term conditions

Good

There were systems in place to ensure patients with multiple conditions received one annual recall appointment wherever possible. This helped to offer the patient a better overall experience in meeting their needs. Healthcare professionals were skilled in specialist areas and their on-going education meant they were able to ensure best practice was being followed. Patients with long term conditions were represented on the Patient Participation Group (PPG).

Families, children and young people

Good

The practice ensured care for mothers, babies and young people was safe, caring, responsive and effective. The practice provided family planning clinics, childhood immunisations and maternity services. There was health education information relating to these areas in the practice to keep people informed.

Working age people (including those recently retired and students)

Good

The practice ensured care for working age people and those recently retired was safe, caring, responsive and effective. The practice had extended hours to facilitate attendance for patients who could not attend appointments during normal surgery hours. There was also an online booking system for appointments.

People whose circumstances may make them vulnerable

Good

The practice ensured care for vulnerable people, who may have poor access to primary care was safe, caring, responsive and effective. The practice had arrangements in place for longer appointments to be made available where patients required this and access to translation services when needed. There was a hearing loop system for patients who have hearing difficulties and information available in large print for those with a visual impairment.

Summary of findings

People experiencing poor mental health (including people with dementia)

The practice ensured care for people experiencing a mental health problem was safe, caring, responsive and effective. The practice has access to professional support such as the local mental health team and psychiatric support as appropriate.

Good

Summary of findings

What people who use the service say

We received 13 completed patient CQC comment cards where patients and shared their views and experiences of the service. We also spoke with four patients on the day of our inspection and this included two members of the Patient Participation Group (PPG) and 'Practice Health Champions' (PHC). A PPG is made up of a group of volunteer patients who meet to discuss the services provided by the practice. 'Practice Health Champions' were volunteers who work with staff to find new ways to improve the service and help to meet the health needs of patients and the wider community.

Patients told us the staff were very helpful, respectful and supportive of their needs. They felt all staff communicate well with them well; they were involved and felt supported in decisions about their care. They felt the clinical staff responded to their treatment needs and they were given a caring service. However two of the completed CQC comment cards stated people had difficulty getting through on the phone line to the practice in a morning.

Outstanding practice

- The practice actively supported 'Practice Health Champions' who were volunteers. They work with the staff to find new ways to improve the service and help to meet the health needs of patients and the wider community.

City View Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to City View Medical Practice

The practice has five general practitioners (GP) partners and three salaried GPs (six female and two male). It is a training practice and received its first registrar in February 2009. Working alongside the GPs are three practice nurses and two health care assistants. There is an experienced management team including, a practice manager and assistant manager, and administration/reception staff; a total of 25 members of staff are employed by the practice.

The practice has a Primary Medical Services (PMS) contract. PMS is a locally agreed alternative to General Medical Service (GMS) for providers of general practice. Their registered list of patients is 12,100.

Opening times are: Monday and Thursday 8am – 8.00pm, Tuesday, Wednesday and Friday 8am – 6pm. The practice is closed from 12 noon on the second Tuesday of every month and this is for training purposes.

When the practice is closed, out-of-hours cover for emergencies is provided by telephoning the normal surgery telephone number. Alternatively, urgent healthcare advice is provided by telephoning the Out of Hours 111 service.

In addition to the general GP services, the practice offer a range of specialist clinics/services and these include:

Antenatal/postnatal – maternity services, child health surveillance check-ups for under 5 years, long term conditions, family planning, contraception implants, immunisations and vaccinations and minor surgery.

Why we carried out this inspection

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

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 the CQC at that time.

How we carried out this inspection

Before visiting the practice, we reviewed information we hold about the service and asked other organisations to share what they knew about the service. We asked the surgery to provide a range of policies and procedures and other relevant information before the inspection.

We carried out an announced inspection visit on14 October 2014. During our inspection we spoke with staff including GPs, practice manager, practice nurses, and administration and reception staff.

Detailed findings

We spoke with four patients who used the service and this included two people who were members of the Patient Participation Group (PPG) and 'Practice Health Champions' (PHC). We also reviewed CQC comment cards where patients and members of the public shared their views and experiences of the service.

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?

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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Good

Are services safe?

Our findings

Safe Track Record:
The practice had systems in place to monitor all aspects of patient safety. Information from the Clinical Commissioning Group (CCG) and Healthwatch indicated the practice had a good track record for maintaining patient safety. Staff we spoke with were clear and understood their responsibilities to raise significant events. This included the process to report them internally and externally where appropriate.

Information from the Quality and Outcomes Framework, which is a national performance measurement tool, showed that in 2012-2013 the practice was appropriately identifying and reporting incidents.

There were policies and protocols for safeguarding vulnerable adults and children. Any concerns regarding the safeguarding of patients were passed onto the relevant authority.

Learning and improvement from safety incidents:
We reviewed how the practice managed serious or significant incidents. Incidents were reported directly to the CCG as an on line service. Records showed the system in place was managed in line with guidance issued by the National Patient Safety Agency; there were up to date policies and protocols in place.

We saw incidents were investigated; action taken and where appropriate, staff learning and changes to practice had taken place. For example, it was identified clinicians had not always reviewed letters as soon as they came into the practice. As a result of these findings, as letters came into the practice they were now seen by the clinicians and dealt with in a timely way. Staff we spoke with also confirmed they were made aware of incidents that had taken place and these were discussed and learning was shared with relevant staff.

Safety alerts were reviewed by the practice manager. They were then emailed to relevant staff, discussed at their clinical/ staff meeting, together with the action they had taken.

Reliable safety systems and processes including safeguarding:
We saw a proactive approach to safeguarding was followed by the GP safeguarding lead and referrals were made to the appropriate safeguarding agencies. On the day of the inspection we spoke with two GPs who told us they had level three safeguarding training and this included adults and children. They were aware of the national and local guidelines and were able to give examples where they had identified patients at risk and the action they had taken in line with current protocols. Other staff had received safeguarding training relevant to their role and this included how to use processes for safeguarding vulnerable adults and children. They demonstrated an understanding of safeguarding patients from abuse and the actions to take should they suspect anyone was at risk of harm.

Systems were also in place within the electronic patient records, to alert staff when patients identified as vulnerable adults or children attended for consultation. Any concerns regarding the safeguarding of patients were passed onto the relevant authorities as quickly as possible.

In the practice waiting room we saw posters offering the use of a chaperone during consultations and examinations. Staff told us they asked if patients would like to have a chaperone during an examination. Staff also told us when chaperones were needed the role was carried out by nursing staff.

Medicines Management:
A representative from the Leeds CCG Medicines Optimisation Team visited the practice weekly and gave advice on safe, effective prescribing of medication. Where medication needed regular monitoring such as Warfarin and Insulin this had taken place. They also monitored and audited medicines to ensure the practice followed good practice guidance, published by the Royal Pharmaceutical society.

The prescribing GP Lead attended prescribing meetings. At their monthly clinicians meetings GPs discussed updates, including prescribing errors and where applicable, changes in practice as a result.

We saw emergency equipment was available in the surgery which included emergency medicines. The practice had arrangements for managing medicines to keep patients safe and correct procedures were followed for the prescribing, recording, storage, dispensing and disposal of medicines.

There were standard operating procedures (SOP) in place for the use of certain medicines and equipment. The nurses used patient group directives (PGD). PGDs are specific

written instructions which allow some registered health professionals to supply and/or administer a specified medicine to a predefined group of patients, without them having to see a doctor for treatment. For example, flu vaccines and holiday immunisations. PGDs ensure all clinical staff follow the same procedures and do so safely.

The data received from NHS England in relation to immunisations of children, in April 2013 showed 100% of the five year, children age group had received their vaccinations. The rate of uptake of vaccinations for patients aged 65 and older was the same as the England average of 0.7320

Vaccines were stored in a locked refrigerator. Staff told us the procedure was to check the refrigerator temperature every day and ensure the vaccines were in date and stored at the correct temperature. The practice nurse showed us their daily records of the temperature recordings and the desired refrigerator temperature for storage was maintained.

Cleanliness & Infection Control:

The practice had a designated lead for infection control who had received training for this role. There was an infection prevention and control (IPC) policy dated February 2014. We observed all areas of the practice to be clean, tidy and well maintained.

An infection control audit had taken place by the infection control, hospital trust staff in October 2013. A repeat audit took place in January 2014 and the recommendations from the previous audit had been completed. We were told a member of staff monitored the cleaning schedules and passed them to the practice manager to address, when issues had been identified. Additionally we saw the practice carried out infection control audits each monthly. Between July and September 2014 the overall score for the practice ranged from 97% to 99%.

The practice had access to spillage kits to enable staff to appropriately and effectively deal with any spillage of body fluids. Sharps bins were appropriately located and labelled.

Equipment:

We saw equipment was available to meet the needs of the practice and this included: a defibrillator and oxygen, which were readily available for use in a medical emergency. Routine checks had been carried out to ensure they were in working order.

We saw that equipment had up to date annual, Portable Appliance Tests (PAT) completed and systems were in place for routine servicing and calibration of medical equipment where required. The sample of portable electrical equipment we inspected had been tested and was in date.

Staffing & Recruitment:

The practice had a recruitment policy which had been reviewed on September 2013 and the next review date was September 2015. They also had an employment of offenders/ Disclosure and Barring Service (DBS) policy, reviewed November 2013, to be reviewed November 2014.

We inspected the recruitment records of two GPs. We found one of the GP had an enhanced DBS check undertaken in August 2014. The second GP had been working within a temporary contract at the practice for the last two years. The practice manager told us that this persons contract had recently become permanent and therefore they were updating their recruitment records.

Records showed on-going checks of staff registration with professional bodies. Such as the Nursing and Midwifery Council (NMC), which confirmed nurses were registered and able to continue to practice.

There were five GP partners; two full time and three part time, three salaried GPs; one full time and two part time and one full time GP registrar. The GPs spoken with on the day had received revalidation and appraisals. One of the GPs were working towards a Postgraduate Certificate in Clinical Education

One of the GP partners told us they had good levels of staff which were constantly reviewed and should there be a shortage of cover then locums were booked. We saw the practice had a locum pack and this ensured they were aware of the practices policies and procedures and ensured the continuity of safe patient care. They also said that as the practice increased they were constantly monitoring and had increased GP sessions in response to the rising list size of the practice.

Monitoring Safety & Responding to Risk

The practice had clear lines of accountability for patient care and treatment. Each patient with a long term condition and those over 75 years of age had a named GP. The GPs, nurses and practice manager also had lead roles such as safeguarding lead, medicine management lead and infection control lead. Each lead had systems for keeping staff informed and ensuring they were using the

Good

Are services safe?

latest guidance. For example, safety alerts were circulated via email to staff and relevant changes were made to protocols and procedures within the practice. The practice manager and staff also told us the alerts were discussed at relevant staff meetings where the information was re-enforced.

Areas of individual risk were identified. Information relating to safeguarding were displayed and staff had received relevant training.

The practice told us the biggest issues they faced over the last two years were the appointment and telephone system. The reasons behind this were thought to be an increasing list size and the influx of non-English speaking patients. This meant the practice staff were struggling to have enough capacity for on the day appointments. They were aware this had caused patient frustration and were working hard to address this. As a result they monitored the systems and in April 2014 had introduced five minute appointments for new or sudden onset of urgent symptoms. When booking these appointment patients were asked the nature of their problem and this was recorded for the GP to see. Should their condition not fit into the urgent criteria or the GP felt that a longer appointment was needed then this would be arranged. We were told the practice would continue to monitor the system and these changes should increase the number of patients that can be seen every day.

Arrangements to deal with emergencies and major incidents:

We reviewed the business continuity plan for the practice. The plan identified management plans for dealing with potential foreseeable risks and disruptions to the practice. This ensured systems were in place to monitor the safety and effectiveness of the service in the event of an incident to reduce the risk of patients coming to harm. Staff told us they had access to this information and contact numbers. There were mobile phones and a lap top to use should the phone lines and computer system not be available. We were also told that each night the staff printed off the next day's appointments. This was to ensure if the computer system was not available the following day, then the staff would have the information they needed to continue with the service.

We found staff received annual cardiopulmonary resuscitation (CPR) training and staff we spoke with told us they were up to date with their training. Emergency medicines and equipment were accessible to staff and systems were in place to alert GP's and nurses in the event of an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment:

We found care and treatment was delivered in line with local CCG, recognised national guidance, standards and best practice. For example, the clinicians used National Institute for Health and Care Excellence (NICE) quality standards and best practice in the management of conditions such as diabetes. We saw The British Thoracic Society (BTS) guidelines were used in the treatment and management of asthma. We were told any updates were circulated to staff and where appropriate, discussed at their clinical meeting.

The practice also held multiple clinics to meet the needs of the practice population; these included, those patients with long-term conditions such as diabetes and chronic obstructive pulmonary disease (COPD). Other clinics included: new patient assessment, medication reviews, childhood immunisation and monitoring, cervical cytology clinics, antenatal and post natal clinics and general health checks.

The practice was actively developing self-management plans with patients. We were shown examples of patient's long-term conditions management plans and these included a COPD plan.

The practice had registers for patient needing palliative care, diabetes, asthma, and COPD. This helped to ensure each patients condition was monitored and ensured their care was regularly reviewed. Additionally regular palliative care meetings were held and they included other professionals involved in the individual patients care.

The practice used leaflets in various languages to help patients make informed decisions about their care or treatment. These were also available on the practice website.

Management, monitoring and improving outcomes for people:

We found there were mechanisms in place to monitor the performance of the practice and the clinician's adherence with best practice to improve outcomes for people. For example, with support from the Leeds CCG Medicines Optimisation Team, the medicine lead GP monitored prescriptions to ensure the practice used the most appropriate medication and followed good practice guidance published by the Royal Pharmaceutical Society.

We saw the practice had a system in place for monitoring patients with long term conditions and this included learning disabilities.

Additionally the clinicians monitored their performance against the local Quality and Outcomes Framework (QOF) targets. We saw evidence that audits, learning, updates and action taken were monitored and shared at their clinical meetings. Other audits we saw evidence of and which were carried out by the practice included, medication, for example, the monitoring of patients on warfarin. We also saw an audit around the referral of patients with cancer to ensure they were referred within the government target time, and a contraception intrauterine device audit.

We saw minutes of a meeting where the practice target for providing flu vaccines was discussed. The practice had acknowledged they were finding it hard to meet their target; as a result they had booked a locum nurse to give the flu vaccines and increase uptake.

Effective staffing:

Staff employed to work within the practice were appropriately qualified and competent to carry out their roles safely and effectively. This included the clinical and non-clinical staff.

Records demonstrated that new staff were provided with induction training and were monitored during their first few weeks in post. They also were able to access relevant up to date policy documents, procedures and guidance. There was an up to date 'locum pack' containing local protocols, procedure and guidance for them to follow.

Staff had one to one supervisions and received annual appraisals. Clinical staff had clinical supervision and felt that this was a valuable process.

The practice ensured all staff kept up to date with both mandatory and non-mandatory training and we saw evidence of this in the files we inspected. The training staff received included: fire awareness, safeguarding adults and children and basic life support. Staff also confirmed they received training specific to their roles and this included, cytology update training, wound management, heart disease, diabetes, and COPD.

Working with colleagues and other services:

We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. We were told Community Matrons

Good

Are services effective?

(for example, treatment is effective)

helped in the care of patients with long term conditions. There were regular meetings with multi-disciplinary teams within the locality. This included district nurses and health visitors. We saw multidisciplinary meetings were held to discuss patients on the palliative care register and support was available irrespective of age. There were also regular informal discussions with these staff.

The practice had systems in place for recording information from other health care providers. This included out of hours services and secondary care providers, such as hospitals. We were informed by staff that all clinical correspondence received by the practice was reviewed by the clinical staff and actioned where appropriate. The information was then scanned onto the patient's electronic notes.

We spoke with practice staff about the formal arrangements for working with other health services, such as consultants and hospitals. They told us how they referred patients for secondary (hospital) care and tried to book an appointment using the choose and book system. Arrangements were carried out wherever possible, before the patient left the surgery.

Information Sharing:

The practice had details informing patients of how their records were held on a computerised, secure, clinical system. The information explained the facility and how, with the patients consent, the practice could share their records with other medical providers of care.

Consent to care and treatment:

We found the healthcare professionals understood the purpose of the Mental Capacity Act (2005) and the Children Act (1989) and (2004). They confirmed their understanding of capacity assessments and how these were an integral part of clinical practice. They also spoke with confidence about Gillick competency assessments of children and young people. This is to check whether these patients have the maturity (at age 16yrs or younger) to make decisions about their treatment. Clinical staff we spoke with understood the principles of gaining consent including issues relating to capacity.

The practice had a consent policy available to assist staff and access to relevant consent form documentation.

Health Promotion & Prevention:

All new patients were encouraged to complete a registration form and attend a New Patient Medical appointment with the healthcare team.

The practice nurses were responsible for the recall, monitoring and health education for people with long term conditions (LTC) and these included conditions such as diabetes, hypertension and COPD. The clinical staff had a clear understanding of the number and prevalence of conditions being managed by the practice. They told us how they recalled patients with these conditions, usually annually or more regularly if required. They ensured no one missed being sent a follow up review. Blood tests were carried out by the health care assistant before attending an appointment with the nurse. The results of the blood test could then be discussed at their consultation without having to return for a second appointment. Patients with more than one LTC were usually offered one recall appointment where able, to improve the patient experience.

The practice website promoted the City View Patient Health Champion (PHC) Allotment (gardening) Scheme and information about how to become healthy and the contact details of the Health Champion Staff. We spoke with members of the PHC's on the day of our inspection and saw displays of the allotment produce. The members were knowledgeable and enthusiastic in their role and were seen to be advocates for the patients and practice. The practice also had information and advice relating to free advice, structured support and appointments with qualified practitioners regarding alcohol, smoking, weight loss, counselling, activity and healthy eating.

Information available included the bowel cancer screening programme for those aged 60 – 69. Those registered with a GP would automatically be sent a free kit to help detect bowel cancer early. Patients who were aged 70 or over were informed of a free telephone number they could call to request your free kit.

The practice reported 40% of patient's whose language was recorded, did not have English as their first language. We saw information was available in different languages and this included on line services; there were translation services available.

Good

Are services caring?

Our findings

We received 13 completed patient CQC comment cards where patients and members of the public shared their views and experiences of the service. We also spoke with four patients on the day of our inspection and this included two people who were members of the Patient Participation Group (PPG) and 'Practice Health Champions' (PHC). We spoke with people from different age groups; who had varying levels of contact and varying lengths of time registered with the practice.

Respect, Dignity, Compassion & Empathy:
Staff were familiar with the steps they needed to take to protect people's dignity. The practice had an electronic booking in system for those who did not wish to announce their name to the reception staff. There was a consulting room should patients like to speak in private with a member of staff. All consulting rooms were private and patients who completed the CQC comment cards told us their privacy and dignity was always respected.

The results of the practice survey dated 2013, showed 90% of patients stated they felt the practice was welcoming; the staff were friendly and helpful. Staff treated patients with respect and care.

Care planning and involvement in decisions about care and treatment:
Patients told us they had been involved in decisions about their care and treatment. They told us their treatment was explained to them and they understood the information before giving consent.

We were told patients had a chance to ask questions during a consultation and everything was explained.

Patient/carer support to cope emotionally with care and treatment:
We saw information in the practice about advocacy, bereavement support and counselling services. Staff were also aware of contact details for these services when needed.

The GPs told us that patients who were referred on a two week wait for a hospital appointment, i.e. there was suspicion of cancer, would have their condition explained to them; they would also be given an information leaflet.

Palliative care meetings with clinical staff and community health professionals were held to discuss patient treatment, care and support. This ensured they received co-ordinated care and support.

The practice had on line information leaflets to down load in different languages, and links to other websites for health related information. For example: Common health questions, and self-help guides. Additionally, we saw a number of leaflets were displayed in the waiting room for patients to access. This included, 'Help is at hand' A guide to practical and emotional issues following suicide or sudden traumatic death. 'Leeds Cancer Support' – "here to help you through and after cancer." (Information for patients, families and friends.)

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs:
In February 2014, 18 volunteer patients who used the service were trained to be Practice Health Champions (PHC). Minutes of meeting minutes showed they had been involved on a number of projects to promote health awareness and improve the health of the local community. These included awareness campaigns: smoking cessation, healthy weight, smear campaign and being active. For example, the PHC set up a walking group. Members of the group had been to one of the local community centres to promote the uptake of cervical smears and had also attended the Beeston Festival in the promotion of health education for the wider community.

The practice also had a Patient Participation Group (PPG) Both groups were proactive and assisted in improving the service and experiences for patients. They had a joint meeting and endeavoured to ensure they represented the practice population. They ensured notices were in different languages in areas such as: practice notice boards, the patient information screen, and leaflets in the practices waiting room. Following the outcome of the practice survey in 2013 an action plan was agreed at this meeting. The practice had listened to what people had said and reviewed the appointment system to ensure more available appointments. As a result the appointment system had changed with a review to create more available appointments. This occurred in April this year and a survey is to be repeated in November 2014 to obtain feedback from patients who use the service.

The consulting rooms were large with easy access for patients with mobility difficulties, designated parking spaces and toilets for disabled patients.

Tackling inequity and promoting equality:
We were told by staff and saw, the appointments system was monitored. Where patients were delayed in seeing their GP at a booked appointment the reception staff apologised and kept them informed. The PHC took the opportunity to involve people wherever possible in health promotion and therefore improve their experience at the practice including their delay in appointment. The PHC were seen escorting people in the practice and this included assisting people to find the location of consulting rooms and seating areas.

As a result of listening to people, the practice had extended their hours to facilitate attendance for patients who could not attend appointments during normal surgery hours. This also allowed for flexible access for vulnerable population groups and working age people, including those in full time education.

The practice reviewed the post hospital discharge list and ensured patients were reviewed to ensure their needs continued to be met.

The GPs also held reviews for their nursing home patients. Each of these patients had a named GP and this included patients in the practice with long term conditions and those over 75years of age.

Access to the service:
The surgery opening times were detailed in the practice leaflet which was available in the patient waiting room and on their website. The practice Monday and Thursday 8am – 8.00pm, Tuesday, Wednesday and Friday 8am – 6pm. The practice is closed from 12 noon on the second Tuesday of every month and this is for training purposes.

The 2013 patient survey showed 88% of patients were satisfied the surgery was open at times when they could attend an appointment. Additionally appointments were available which patients could access by booking on line, attending in person or asking for a telephone consultation and these could be booked up to four weeks in advance. The GPs and staff told us emergency, same day appointments were always available. Home visits were also available where appropriate, and included visits to patients who were house-bound.

Nurse appointment could be booked routinely for a variety of conditions and health promotion, including: Asthma, COPD, Hypertension, Cardiac disease, Diabetes, Family Planning, Weight Management, Travel and Childhood Vaccines, "Over 40" Health Checks.

The practice website also showed information relating to the texting messaging service that would be available from November. Unless a patient stated otherwise, they would be sent a text by the practice to remind them of their next imminent appointment.

Repeat prescriptions were available to re-order either in person, on-line, posted, faxed or emailed. Information relating to this was available in the practice leaflet and on their website.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns & complaints:

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice and reviewed them each year.

We were also informed by the practice manager and staff, that all complaints or information of concern were discussed at the GP/clinical meeting and shared at their practice meetings. This included the action taken and learning for the practice.

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:
There was an established management structure within the practice. The practice manager, GPs and staff were clear about their roles and responsibilities and the vision of the practice. They worked closely with the local CCG and were committed to the delivery of a high standard of service and patient care.

Patients were encouraged to be involved in decision making. The Practice engaged with patients in various ways, including Patient Participation Group (PPG) and Practice Health Champions PHC) meetings. We saw from the minutes of meetings, including the practice TARGET training days that patients and staff were involved in developing and achieving the vision of the practice.

Monitoring took place, and this included audits to ensure the practice was achieving targets and delivering safe, effective, caring, responsive and well led care of a high standard at all times.

Governance Arrangements:
The practice had effective management systems in place. The practice had policies and procedures to govern activity and these were accessible to staff. We saw the policies incorporated national guidance and legislation, were in date; reviewed and updated. We found clinical staff had defined lead roles within the practice. For example, the management of long term conditions, safeguarding children and adults, medication prescribing and one of the GPs had a specialist interest in minor surgery. Records showed and staff confirmed that they had up to date training in their defined lead role.

The practice held meetings where governance, quality and risk were discussed and monitored.

One of the lead GPs regularly met and worked with the local CCG, and the practice used the Quality and Outcomes Framework (QOF) to measure their performance. We were told the clinical team regularly discussed QOF data at their meetings and where appropriate action plans were agreed monitored and reviewed.

Leadership, openness and transparency:
The practice was committed to on-going education, learning and individual and team development of staff. The performance of staff was the subject of monitoring and appraisal at all levels; which reflected the organisational objectives. There were leading roles within the team for different aspects of the service. For example, infection control and vaccinations/ immunisation programme.

There was good communication between staff. The practice had a proactive approach to incident reporting. They discussed if anything however minor could have been done differently at the practice.

Staff we spoke with told us that all members of the management team were approachable, supportive and appreciative of their work. They were encouraged to share new ideas about how to improve the services they provided. Staff also spoke positively about the practice and how they worked collaboratively with colleagues and health care professionals.

Practice seeks and acts on feedback from users, public and staff:
The practice had gathered feedback from patients through the patient participation group and patient surveys. We reviewed the most recent data available for the practice on patient satisfaction which was from their survey in 2013. The evidence from this demonstrated that patients were generally satisfied with the care and treatment provided by the practice and how they were treated. Patients were not satisfied they were not always able to see their doctor of choice. It was also noted that two of the GPs had been off sick and a number of locum GPs had been used. It was agreed, with the return of permanent staff the situation should improve. Additionally patient's satisfaction of the appointment system had reduced from the previous year. As a result of the finding from the 2013 survey an action plan was agreed between the PPG and the practice. For example, the appointment system had been reviewed and adapted to increase the access and availability of appointments. We saw through the minutes of the PPG meetings the appointment system, together with the outcome of the survey action plan, were monitored and reviewed.

Staff told us they attended staff meetings and had the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They also told us how they felt valued and supported in their work and the culture was one of openness and transparency.

Are services well-led?

Good

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

The PPG/ PHC members we spoke with felt the staff listened to their views and welcomed feedback to inform how the practice could best meet the needs of their patient groups.

Management lead through learning & improvement:

We found that GPs were committed to continuous learning, improvement and innovation. Clinical meetings took place each week and improvements through learning were discussed and shared where appropriate with the practice team.

Staff we spoke with discussed how action and learning was shared with all relevant staff. Meeting minutes we reviewed confirmed that this occurred. Staff we spoke with could describe how they had improved the service following learning from incidents and reflecting on their practice.

A GP from the practice also attended the Clinical Commissioning Group (CCG) protected time education initiative. We were told that the practice staff learnt together on TARGET (Time for Audit, Research, Governance, Education and Training) days and also when mandatory training was undertaken, such as basic life support. Additionally staff attended individual training to ensure they had the skills and competencies to do their job.