Barmston Medical Centre

Quality Report

Westerhope Road, Washington, Tyne and Wear, NE38 8JF
Tel: 0191 4190333
Website: www.intrahealth.co.uk

Date of inspection visit: 15 April 2015
Date of publication: 11/06/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Barmston Medical Centre on 15 April 2015. We inspected the main surgery at Barmston and the branch surgery at The Galleries Health Centre. The practice was rated as good for all domains and population groups.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There were comprehensive safety systems in place.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified. All clinical staff had received safeguarding level three training.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Data showed that patients rated the practice inline or just below the national averages for being caring. We saw that staff were considerate with patients, treated them with understanding and maintained confidentiality.
- Information about services and how to complain was available and easy to understand.
- Most patients we spoke with and those who completed CQC comment cards indicated they felt they could obtain appointments, including urgent appointments, when needed.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by the management team. The practice proactively sought feedback from staff and patients, which they acted on.

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

The provider should:

- Provide all staff with adult safeguarding training.
- Provide effective training for staff who carry out the role of chaperone.

Summary of findings

- Improve systems and processes for fire safety.
- Implement systems to ensure that all patients with learning difficulties are offered regular health checks.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Patients and staff were protected by safety systems. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used opportunities to learn from incidents to support improvement. The practice had regular multidisciplinary meetings to discuss the safeguarding of vulnerable patients. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and managed. The practice had enough staff in place to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care excellence and used it routinely. Patients' needs were assessed and care and treatment was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

The practice had systems in place for completing clinical audit cycles to review and improve patient care. Staff had received training appropriate to their roles and any further training had just been identified and planned for. There was evidence of appraisals for all staff. Staff worked with multidisciplinary teams. Discrimination was avoided when making care and treatment decisions.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice inline or just below the national averages for being caring. Patients told us and CQC comment cards indicated that patients were treated with compassion, dignity and respect and were involved in decisions about their care and treatment. Information to help patients understand services available was easy to understand. We also saw staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They reviewed the needs of their local population to secure improvements to services where these were identified. Most

Summary of findings

patients said they found it easy to make an appointment, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs.

Information about how to complain was available and easy to understand and evidence showed that the practice responded to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. They had a clear vision and although they did not have a documented strategy they knew what the priorities for the practice were. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity, although not always up to date, and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice had a lower than national average number of patients over the age of 65 (9%). All patients over the age of 75 had a named GP. The practice made decisions about care planning for elderly patients at their multi-disciplinary team meetings. Where appropriate the patient's carer was included in the process. There were care plans in place for 2% of the practice population, which was the national target, with the most complex needs, which included the elderly, to help avoid unplanned admissions into hospital.

People with long term conditions

Good

There were clinical leads for the management of long term conditions which were shared between the GPs and nurse practitioners.The clinical leads covered the recall of these patients for reviews; these were carried out at least annually along with opportunistic reviews.The practice's computerised patients records were used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. For those people with the most complex needs, the practice worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice had systems to manage and review risks to vulnerable children and young people. They met with health visitors on a quarterly basis to discuss child safeguarding issues, immediate issues were discussed at the weekly practice meeting. Concerns were raised with the health visitor when babies and children failed to complete their vaccination programme. The practice had a dedicated GP appointed as the lead for safeguarding children.

The practice offered baby and anti-natal clinics. Nationally reported data for 2013/14 showed the practice offered child development checks at intervals that were consistent with national guidelines. They offered routine immunisations for babies and children under five, during clinic appointments.

The practice had recently participated in 'Dr Spike's Fun Day', a health awareness promotion day for parents of young children which was held at the local Surestart Centre (centres which provide

Summary of findings

access to a range of early childhood services). Feedback was taken from the parents and the practice assisted in designing a leaflet for parents on services available to them from primary and secondary care.

Working age people (including those recently retired and students)

Good

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services they offered to ensure these were accessible, flexible and offered continuity of care. Appointments were available outside normal working hours; there were surgeries running until 7pm on Tuesday and Wednesday evenings and the Barmston surgery was open on a Saturday morning. Patients we spoke with commented on the usefulness of this. There were telephone appointments available to allow patients to speak to a practice nurse or GP on the telephone. Routine appointments were bookable up to four weeks in advance. Repeat prescriptions could also be ordered via the telephone, calling into the practice on-line or by fax.

People whose circumstances may make them vulnerable

Good

The practice worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and organisations. Staff we spoke with knew how to recognise signs of abuse in vulnerable adults and children. One of the nurse practitioners was the lead for vulnerable adults. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. Carers were offered the flu vaccine and screening for depression.

The practice held a register of those patients with a learning disability; however annual health checks were not up to date due to a member of staff leaving.

Vulnerable patients, for example, patients who were illiterate were coded on the practice computer system to ensure the staff could identify them and ensure their needs were met. A GP gave us an example of a patient who had become homeless who the practice had referred to social services for support.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice worked closely with mental health services. An in house counsellor attended the practice on a weekly basis. The practice liaised with MIND (a mental health charity) and primary care mental health workers. These teams provided services from both surgeries and there were also referrals onwards to services for those experiencing poor mental health.

The Barmston main surgery had a board in the waiting area dedicated to dementia and there were leaflets of advice, information regarding the screening available and how dementia can be diagnosed. The practice had a named member of staff who was a dementia champion and staff had received dementia awareness training.

Summary of findings

What people who use the service say

We spoke with 11 patients during the inspection, including one member of the Patient Participation Group (PPG). Of the 11 patients we spoke with seven patients at the Barmston surgery and four at the Galleries branch surgery. Most of the patients were satisfied with the care they received from the practice. Words used to describe the service included good, nice staff and quite satisfied. Three patients we spoke with felt that in order to obtain an appointment they had to ring as close to 8am as possible. Two patients said the practice frequently used locums which did not ensure continuity of care.

We reviewed 18 CQC comment cards completed by patients prior to the inspection. Two were completed at the Galleries branch surgery and 16 at the Barmston surgery. Thirteen of the cards were positive about the services; words used to describe the service included good, friendly and helpful staff. Two comment cards remarked that the Saturday morning opening was useful.

The five comment cards with negative comments all said the practice was good and staff helpful, however the two themes from them were a lack of regular doctors and problems in obtaining an appointment.

The latest GP Patient Survey completed in July 2014 showed most patients were satisfied with the services the practice offered. The results were:

- Percentage of patients who would recommend the practice – 74.1% (national average 79.1%);
- Percentage of patients who described the overall experience of their GP surgery as good or very good 84.7% (national average 85.7%);
- Percentage of patients satisfied with phone access – 90.5% (national average 75.4%);
- GP Patient Survey satisfaction for opening hours – 83.8% (national average 79.8%).

Areas for improvement

Action the service SHOULD take to improve

- Provide all staff with adult safeguarding training.
- Provide effective training for staff who carry out the role of chaperone.
- Improve systems and processes for fire safety.
- Implement systems to ensure that all patients with learning difficulties are offered regular health checks.

Barmston Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor, and a specialist advisor with experience of GP practice management.

Background to Barmston Medical Centre

The Barmston Medical Centre has a main surgery in Barmston and a branch surgery in Washington town centre close to the Galleries shopping centre. The practice provides services to approximately 4,800 patients from the two locations;

- Westerhope Road, Washington, Tyne and Wear,NE38 8JF
- The Galleries, Washington Centre, Washington, Tyne and Wear, NE38 7NQ

We visited both of these locations as part of the inspection of the practice. The area covered by both surgeries is predominately the postcode areas of NE37 and NE38.

Both surgeries are located in purpose built premises. The surgery at Barmston has patient facilities on the ground floor and there are disabled parking spaces in the patient car park, wheelchair and step free access. The branch surgery at the Galleries in Washington is one of four practices based in a purpose built health centre. The facility is part of the Galleries shopping complex and the reception area is shared with the local library on the first floor, there is a ramp for easy access. A lift is available to take patients to street level at the rear of the premises, there are two disabled bays shared with the other three practices.

The provider of the service is Intrahealth a corporate provider of NHS primary care services. The practice has three salaried GPs two female and one male, two nurse practitioners, two practice nurses and two healthcare assistants. There is a practice manager and seven staff who carry out reception and administration duties.

Surgery opening times at both surgeries are Monday 8am to 6.30pm, Tuesday and Wednesday 8am to 7pm. Thursday and Friday 8am to 6.30pm with extended opening at Barmston on a Saturday morning 8.30am to 12pm.

The practice is commissioned to provide services within an Alternative Provider of Medical Services Agreement (APMS) with NHS England.

The service for patients requiring urgent medical attention out of hours is through the 111 service and Primecare (Primary Care Sunderland) Sunderland.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

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.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included the local Clinical Commissioning Group (CCG) and NHS England.

We carried out an announced visit on 15 April 2015. During our visit we spoke with a range of staff. This included the provider's clinical director and operational manager. From the practice we spoke with GPs, practice manager, practice nurse and reception and administrative staff. We also spoke with 11 patients. We reviewed 18 CQC comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

As part of our planning we looked at a range of information available about the practice. This included information from the General Practice Outcome Standards (GPOS) and the Quality Outcomes Framework (QOF). The latest information available to us at the time of the inspection indicated there were no areas of concern in relation to patient safety.

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included reported incidents, national patient safety alerts as well as complaints received from patients. For example, it was found that there had been missed actions from hospital letters which a GP had signed but not arranged for blood samples to be taken for monitoring. The incident was recorded and lessons were learned; further training and advice was given to staff.

Staff we spoke with were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety.

We reviewed safety records, incident reports and minutes of meetings in the last 12 months. These showed the practice had managed these consistently over time and so could demonstrate a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. They were open and transparent when there were near misses or when things went wrong. There were records of significant events and we were able to review these, they went back to 2009, there had been 19 in the last year. We saw examples of two significant events where learning points and feedback from the review meeting and any action which was necessary was taken.

The GPs and practice manager told us that significant events were discussed as soon as practicable, usually at the weekly practice meeting. There was a joint annual review of significant events and complaints. The practice manager had overall responsibility for the significant event processes. Staff could describe recent significant events and action taken by the practice. They told us that they had dedicated training sessions where they would discuss incidents and take away learning from them.

National patient safety alerts came to the practice via a generic email or hard copy. The practice manager had responsibility to disseminate the alerts to the most appropriate members of staff. The practice manager would then ensure the appropriate staff read them, they showed us the audit trail they used to ensure these had been seen and read and action taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. They met with health visitors on a quarterly basis to discuss child safeguarding issues, immediate issues were discussed at the weekly practice meeting. Concerns were raised with the health visitor when babies and children failed to complete their vaccination programme. The practice had a dedicated GP appointed as the lead for both safeguarding children and one of the nurse practitioners was the lead for vulnerable adults.

Practice training records confirmed GPs, practice nurses and healthcare assistants received child safeguarding level 3 training, non- clinical staff received level one child safeguarding training. Approximately half of the staff had received adult safeguarding training. Those who had not received this training were scheduled to receive it in the next few months.

Staff we spoke with were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had a chaperone policy which was the provider's corporate policy. It was dated December 2013. The practice manager said ideally clinical staff would usually act as chaperone, however if they were not available administration staff would carry out this role. All staff had received a disclosure and barring check (DBS). Staff had received informal training on this role from a GP.

Good

Are services safe?

We asked staff about the procedures for chaperoning and not all of them were aware of the correct processes. A notice was displayed in the patient waiting areas to inform patients of their right to request a chaperone.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found all medicines were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, this described the action to take in the event of a potential failure. Stock control of medicines was managed by the practice nurses.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Blank prescription forms were handled according to national guidelines and were kept securely.

Repeat prescribing which was in line with national guidance and was followed in practice. The practice protocol on repeat prescribing complied with the legal framework and covered all required areas. We saw an example of the process that was followed when a patient's medication had been changed following a visit to hospital. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

Cleanliness and infection control

We saw both practices were exceptionally clean and tidy. Patients we spoke with told us they were happy with the cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this.

The nurse practitioner was the nominated infection control lead. We saw there was an up-to-date infection control policy which was the provider's own policy. We saw there had been an infection control audit carried out by the infection control lead and the practice manager in February 2015. The infection control lead had been trained in infection control. Staff had received on-line infection control training and the nurse practitioner had provided informal hand washing training.

The risk of the spread of inspection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. The treatment room had walls and flooring that was easy to clean. Hand washing instructions were displayed by hand basins and there was a supply of liquid soap and paper hand towels. The privacy curtains in the consultation rooms were disposable and had the date written on them when they were last changed. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades.

The practice employed their own cleaner at the Barmston surgery. The Galleries surgery was cleaned by cleaners who were employed by NHS property services. There were cleaning schedules in place for use at both surgeries.

We asked about legionella (bacteria found in the environment which can contaminate water systems in buildings) risk assessments at both surgeries. We were told that NHS property services who were responsible for both surgeries would have this information and they did not provide copies to the practice.

Equipment

Staff told us they had equipment to enable them to carry out assessments and treatments which was appropriate for patient's needs. The practice had a range of equipment in which included medicine fridges, patient couches, access to a defibrillator and oxygen on the premises, sharps boxes (for the safe disposal of needles) and fire extinguishers. The oxygen and defibrillator at the Galleries surgery was shared with the other three practices. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date in the last year.

Staffing and recruitment

The practice had a recruitment policy that set out the standards they followed when recruiting clinical and non-clinical staff. Most of the recruitment for the practice was organised off site by the provider. On the day of the inspection staff recruitment records were made available to us. Records we looked at were organised and contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body such as the General Medical Council (GMC). All staff received DBS checks. There were copies of clinician's medical indemnity insurance in their files.

Good

Are services safe?

The practice regularly used locum GPs. The provider recruited locums centrally and there was a member of staff at the provider's head office who oversaw this. We saw an example of recruitment checks made on a locum GP before they commenced work at the practice, there were details of DBS and identity checks, a copy of their last appraisal and there was evidence of necessary training such as safeguarding. There were induction packages for different job roles within the practice, for example, we saw copies of inductions for locum GPs and for administration staff.

The managers told us that the recruitment and retention of salaried GPs had been a challenge for the practice in the last two years and they were still actively trying to recruit another salaried GP. Two of the 11 patients we spoke with said the practice frequently used locums which did not ensure continuity of care. A theme from the CQC comment cards which were completed prior to our inspection was that there was a lack of regular doctors at the practice.

At the time of our inspection there were three salaried GPs working in the practice, the sessions they covered equated to 1.8 of a whole time GP. There was also a long term locum at the practice who was covering the vacancy they had for a salaried GP. The provider gave the practice support of a GP for two sessions per week to help monitor performance. The practice had considered other options available to them other than GPs to cover the workload and an additional nurse practitioner had been recruited in the last year.

The operational manager and practice manager organised the cover for GPs on a weekly basis. One of the administration staff organised the cover for administration staff in conjunction with the practice manager.

Monitoring safety and responding to risk

Both surgeries were owned and maintained by NHS property services. The practice manager told us this worked well and both premises were adequately maintained. However, because of this we had problems accessing documentation to confirm some of the arrangements. We were told that the fire risk assessments were held by NHS property services and the practice did not have a copy. There were weekly tests of the fire equipment and fire evacuation drills at the Galleries surgery. There had not been a recent evacuation drill at Barmston surgery. Staff were aware of where to assemble in case of a fire. They had received on-line fire safety training. One of the administration staff was booked on a fire warden training course. We saw a health and safety risk assessment for both surgeries which had been carried out by a contractor.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff training records showed they had all received training in basic life support. Emergency equipment was available including access to oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). Staff we spoke with knew where this equipment was kept and confirmed they were trained to use it. They also showed us the emergency medicines which were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This had been updated regularly and contained relevant contact details for staff to refer to, for example who to contact if the heating system failed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE). We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. Clinical staff had access to a range of electronic care plan templates and assessment tools which they used to record details of the assessments they had carried out and what support patients needed.

There were care plans in place for 2% of the practice population with the most complex needs to help avoid unplanned admissions into hospital. The practice used a system called RAIDR, which was a validated scoring system to identify these patients at high risk of hospital admission. We saw three examples of these care plans. There were care plans in place for patients receiving palliative care.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2013 / 2014. The QOF is part of the Alternative Provider of Medical Services Agreement (APMS) contract for general practices. Practices are rewarded for the provision of quality care. We saw the practice had achieved a score of 95.7% of the points available to them for providing recommended treatments for the most commonly found clinical conditions. This was above both the local Clinical Commissioning Group (CCG) by 0.8 points and England averages by 1.7 points.

There were clinical leads for the management of long term conditions which were shared between the GPs and nurse practitioners. One of the GPs led on atrial fibrillation, another was the diabetes lead and the nurse practitioners covered asthma, chronic obstructive pulmonary disease (COPD) and hypertension. The clinical leads covered the recall of these patients for reviews; these were carried out at least annually, along with opportunistic reviews.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. We saw four clinical audits had been carried out in the last year. There were some examples of two completed audit cycles. For example, an audit was carried out to reduce the prescribing of two antibiotic medicines. There were two audit cycles carried out and a significant drop of 45% in prescribing was seen.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice was undertaking regular reviews of patients with diabetes for known risk factors. The practice met all the minimum standards for QOF in the management of long term conditions such as asthma, chronic obstructive pulmonary disease (lung disease) and epilepsy.

The practice were making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records. We saw that all staff had received training such as basic life support, fire safety, safeguarding children, infection prevention, manual handling, equality and diversity and information governance. Approximately half of the staff had

Good

Are services effective?

(for example, treatment is effective)

received safeguarding adult training, further training was booked for the staff who had not received this. Staff had received dementia awareness training from the Alzheimer's Society.

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

The practice manager provided us records of staff training. Each member of staff had a staff file with training certificates and we saw staff had received an annual appraisal.

Working with colleagues and other services

The practice could demonstrate that they worked with other services to deliver effective care and treatment across the different patient population groups. The practice held multidisciplinary team meetings every month. This included meetings regarding child protection and palliative care. These meetings were attended by the practice's GPs and nurses along with district nurses, social workers, community psychiatric nurses, drug and alcohol workers and palliative care nurses depending upon the meeting.

The practice received a list of unplanned admissions and attendance at accident and emergency (A&E) to support them to monitor this area. This helped to share important information about patients including those who were most vulnerable and high risk.

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service, were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff to pass on, read and action any issues arising from communications with other care providers on the day they were received. The GP who reviewed these documents and results was responsible for undertaking the action required. All staff we spoke with understood their roles and felt the system in place worked well.

We found appropriate end of life care arrangements were in place. The practice maintained a palliative care register. We saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider and the ambulance service.

Information sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. Staff we spoke with told us they ensured they obtained patients' consent to treatment. Staff were able to give examples of how they obtained verbal or implied consent.

GPs we spoke with showed they were knowledgeable of Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the Mental Capacity Act (MCA). We found the GPs were aware of the MCA and used it appropriately. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment. They gave us some examples where patients did not have capacity to consent. The GPs told us an assessment of the person's capacity would be carried out

Good

Are services effective?

(for example, treatment is effective)

first. If the person was assessed as lacking capacity then a "best interest" discussion needed to be held. They knew these discussions needed to include people who knew and understood the patient, or had legal powers to act on their behalf.

Health promotion and prevention

New patients were able to download a pre-registration form and a medical questionnaire from the practice website which, once completed, they could submit electronically into the reception team. Patients could also collect a pre-registration from the surgery. The patient was then required to complete a medical questionnaire. All patients were offered a new patient health check.

Information on a range of topics and health promotion literature was available to patients in the waiting areas of both practice locations, although the branch surgery at the Galleries health centre had a small waiting area where it was difficult to display large amounts of information. Information available included screening services, smoking cessation and child health. The Barmston main surgery had a board in the waiting area dedicated to dementia and there were leaflets of advice, information regarding the screening available and how dementia can be diagnosed. Patients were encouraged to take an interest in their health and take action to improve and maintain it.

We found patients with long-term conditions were recalled to check on their health and review their medications for effectiveness. The practice's electronic system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. Staff told us this system worked well and prevented any patient groups from being overlooked. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening.

The QOF data for 2013/14 confirmed the practice supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy. The data also showed the practice had achieved 100% of the total points available to them for providing recommended care and treatment for patients diagnosed with obesity. This was in line with the local CCG and England averages. The practice had also achieved 100% of the points available to them for providing cervical screening to women. This was 0.8 percentage points above the local CCG average and 2.5 points above the England average.

The practice offered baby and anti-natal clinics. A full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance were offered. Last year's performance for immunisations was in line with averages for the Clinical Commissioning Group (CCG). For example, infant meningococcal C (Men C) vaccination rates for two year old children were 100% compared to 97.9% across the CCG; and for five year old children were 97.1% compared to 97.9% across the CCG. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was 52.6%; the national average was 52.2%.

The practice had recently participated in 'Dr Spike's Fun Day', a health awareness promotion day for parents of young children which was held at the local Surestart Centre (centres which provide access to a range of early childhood services). One of the practice GPs and the practice manager took part in this day. Feedback was taken from the parents and the practice assisted in designing a leaflet for parents on services available to them from primary and secondary care.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with 11 patients during our inspection, including a member of the patient participation group. Most of the patients were satisfied with the care they received from the practice. Words used to describe the service included good, nice staff and quite satisfied. Comments provided by patients in the 18 CQC comment cards completed by patients contained similar comments. Common words used were good, friendly and helpful staff.

We looked at data from the National GP Patient Survey, published in 2014. This included information from the national GP patient survey, data was in line with or just belowthe national averages. For example, the proportion of patients who responded described their overall experience of the GP surgery as good or very good was 84.7%, compared to the national average of 85.7%. The proportion of patients who responded said their GP was good or very good at treating them with care and concern was 77.1%, the national average was 85.3%. Patients who responded said the practice nurses were good at treating them with care and concern was 89.8%, the national average was 90.4%.

We observed staff who worked in both reception areas of the surgeries and other staff as they received and interacted with patients. Their approach was seen to be considerate, understanding and caring, while remaining respectful and professional.

We saw staff who worked in the reception areas made efforts to maintain patients' privacy and confidentiality. Voices were lowered and personal information was only discussed when absolutely necessary. Telephone calls from patients were taken by administrative staff in an area where confidentiality could be maintained.

Staff were familiar with the steps they needed to take to protect patients' dignity. Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in those rooms could not be overheard.

The practice had policies in place to ensure patients and other people were protected from disrespectful, discriminatory or abusive behaviour. The staff we spoke with were able to describe how they put this into practice.

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey information we reviewed showed 76.2% of respondents said the GP was good at involving them in care decisions this was below the national average of 81.8%.

Patients we spoke with on the day of our inspection and CQC comment cards told us that patients felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them time to ask questions and responded in a way they could understand.

We saw that access to interpreting services was available to patients, should they require it. They said when a patient requested the use of an interpreter, staff could either book an interpreter to accompany the patient to their appointment or, if it was an immediate need, then a telephone service was available.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our visit told us staff responded compassionately when they needed help and provided support when required. The CQC comment cards we received were also consistent with this feedback. For example, patients commented that staff were considerate and reassuring.

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups.

The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. Carers were offered the flu vaccine and screening for depression.

There was a palliative care register and regular contact with the district nurses. There were monthly palliative care meetings which involved GPs, district nurses and palliative care nurses.

Good

Are services caring?

Staff told us that if families had suffered bereavement, this was followed up by the practice; the family were contacted to see what support was needed. There was access to a counselling service for the bereaved.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice were responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were taken in to account.

The practice had a lower than national average number of patients over the age of 65 (9%). All patients over the age of 75 had a named GP. The practice made decisions about care planning for elderly patients at their multi-disciplinary team meetings. Where appropriate the patient's carer was included in the process. The practice had a named member of staff who was a dementia champion and staff had received dementia awareness training.

The practice had a palliative care register and had monthly multidisciplinary meetings to discuss patients and their families' care and support needs. The practice worked collaboratively with other agencies and regularly shared information to ensure timely communication of changes in care and treatment.

The practice held a register of those patients with a learning disability; there were 14 patients on the register, however annual health checks were not up to date due to a member of staff leaving. A new member of staff was due to be taking over the role of co-ordinating this in the next few weeks.

Vulnerable patients, for example, patients who were illiterate were coded on the practice computer system to ensure the staff could identify them and ensure their needs were met. A GP gave us an example of a patient who had become homeless who the practice had referred to social services for support.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the practice patient participation (PPG). The group had made suggestions about educating patients about the importance of attending a GP or practice nurse appointment which had been made or cancelling it if it was no longer appropriate. The PPG raised concerns about the car park after resurfacing work had been carried out. They believed it to be unsafe due to the level of the drains. After insistence by the PPG, NHS property services were approached and it was agreed that work would be carried out to make the car park safer.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to telephone translation services if required, for those patients whose first language was not English. One of the salaried GPs spoke Urdu.

The practice worked closely with mental health services. An in house counsellor attended the practice on a weekly basis. The practice liaised with MIND (a mental health charity) and primary care mental health workers. These teams provided services from both surgeries and there were also referrals onwards to services for those experiencing poor mental health.

Both surgeries were located in purpose built premises. All of the treatment and consulting rooms could be accessed by those with mobility difficulties. The surgery at Barmston had patient facilities on the ground floor and there were disabled parking spaces in the patient car park, wheelchair and step free access. The branch surgery at the Galleries in Washington was accessible via a ramp at the front of the building for easy access. A lift was available to take patients to street level at the rear of the premises there were two disabled bays shared with the other three practices in the building.

The practice had male and female GPs, which gave patients the ability to choose to see a male or female GP.

Access to the service

Surgery opening times at both surgeries were Monday 8am to 6.30pm, Tuesday and Wednesday 8am to 7pm. Thursday and Friday 8am to 6.30pm with extended opening at Barmston on a Saturday morning 8.30am to 12pm.

The practice had a mixture of emergency on the day and routine appointments which could be booked up to four weeks in advance. There were telephone appointments available with the GPs and practice nurses. Telephone triage was carried out by a nurse practitioner if there were not enough emergency appointments available on the day.

Most patients we spoke with and most comments cards indicated that patients could obtain an appointment. Three patients we spoke with felt that in order to obtain an

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointment they had to ring as close to 8am as possible which could be difficult and from the CQC comment cards two patients felt in was difficult to obtain an appointment. Data from the national GP survey showed 90.5% of patients said it was easy to get through on the telephone (national average 75.4%).

Information was available to patients about appointments on the practice website and in the patient information leaflet. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. Repeat prescriptions could also be ordered via the telephone, calling into the practice on-line or by fax.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager handled complaints; this was overseen by the provider's medical director.

We saw that information was available to help patients understand the complaints system. Information regarding how to make a complaint was in a leaflet named 'how to complain'.

The practice manager supplied us with a schedule of 28 complaints which had been received in the last 12 months. Themes from the complaints included, patients being unhappy with receiving a letter from the practice regarding them failing to attend an appointment. Patients were also unhappy about continuity of care and having to wait to see a GP of their choice. We looked at a sample of two complaints which had been acknowledged, replied to and an apology given if appropriate.

The practice held an annual review of complaints. Staff told us that they were discussed in staff training and learning and outcomes shared.

Are services well-led?

Good

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

Our findings

Vision and strategy

The provider had a vision to be trusted to provide quality health care to a community where every patient matters and their personal health matters were fulfilled by caring and dedicated services. Their staff values were to take responsibility, act with integrity, fairness and honesty and to be courteous and have good manners and to look after the patients by supporting development, involvement and to explain decisions. Staff told us they knew and understood what the practice was committed to providing and what their responsibilities were in relation to these aims.

Although the provider was unable to show us anything in writing which set out their strategy for the future, it was clear the priorities were to recruit more GPs and to ensure continuity of care. They wanted to ensure timely access for patients with the appropriate clinician. They also were trying to tackle high numbers of 'do not attend' appointments where patients were failing to attend appointments

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared drive on any computer within the practice. We looked at a sample of these policies and procedures. Not all of the policies and procedures were up to date, for example, the chaperone policy had last been updated in December 2013. We were told the provider had recently recruited a member of staff address this issue and review all of their policies and procedures.

The practice used QOF data to manage performance; they were performing in line with the averages of the local CCG and across England as a whole. The practice had identified clinical leads for many of the QOF areas, for example diabetes or chronic obstructive pulmonary disease (COPD) and had clinical leads allocated to them. The provider gave the practice support of a GP for two sessions per week to help monitor performance. We saw that QOF data was regularly discussed at team meetings. There was a system in place for clinical audit which was also used to improve outcomes for patients.

The practice held regular staff, clinical and practice meetings. We looked at minutes from recent meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

The practice had a documented clear leadership structure from the provider as a larger organisation which set out the clinical and organisational responsibility. The members of staff we spoke with were all clear about their own roles and responsibilities.

We saw from minutes that staff meetings were held regularly. Staff told us that there was an open culture within the practice and they were actively encouraged to raise any incidents or concerns about the practice and feedback from complaints and significant events were shared with them. This ensured honesty and transparency was at a high level.

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

The practice had gathered feedback from patients through patient surveys, comments and complaints received.

The practice had a patient participation group (PPG); however there were only three members. There had been no regular meetings of the PPG since October 2014 due to members being unable to attend; we saw minutes of regular meetings had been held throughout 2014. The practice were actively trying to recruit new members. They had promoted the PPG via posters in the waiting area, the practice leaflet and on the electronic news board in the waiting area. The practice manager told us that any patients providing them with feedback were encouraged to join the group.

The practice manager showed us the analysis of the last patient survey they had carried out, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. The practice published an annual report into the work of the PPG and this was available on the practice website.

NHS England guidance states that from 1 December 2014, all GP practices must implement the NHS Friends and Family Test (FFT). (The FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services. It is a

Are services well-led?

Good

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

continuous feedback loop between patients and practices). We saw the practice had recently introduced the FFT. There were questionnaires available at the reception desk and instructions for patients on how to give feedback. The practice manager told us the comments and feedback would be reviewed regularly.

The practice gathered feedback from staff through staff meetings, appraisals and a provider staff survey. Staff we spoke with told us they regularly attended staff meetings. They said these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We saw the practice also used the meetings to share information about any changes or action they were taking to improve the service and they actively encouraged staff to discuss these points. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they would not hesitate to raise any concerns they had.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. From staff files we looked at, we saw that regular appraisals took place.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. Staff meeting minutes showed these events were discussed, with actions taken to reduce the risk of them happening again.