Denton Park Medical Group

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Denton Park Medical Group on 2 December 2014.

Overall, we rated the practice as good, although there were some areas where the practice should make improvements. Our key findings were as follows:

- Feedback from patients was positive; they told us staff treated them with respect and kindness.
- Patients reported good access to the practice and continuity of care, with urgent appointments available the same day.
- Staff reported feeling supported and able to voice any concerns or make suggestions for improvement.
- The practice was visibly clean and tidy.
- The practice learned from incidents and took action to prevent a recurrence.

We saw the following area of outstanding practice:

- The practice was considered to be outstanding in terms of its care of people whose circumstances may make them vulnerable. For example, a member of staff had taken on the role of administering the system for monitoring the care of patients with learning disabilities, and through personal contact built up a rapport with patients and their carers. As a result of this work, 45 out of 46 patients received their annual medical check during the period April 2013 to March 2014.

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

The practice should:

- ensure issues highlighted following a legionella risk assessment are addressed
- review its procedures for carrying out fire evacuation drills.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Care and treatment was being delivered in line with current published best practice. Patients' needs were being met and referrals to other services were made in a timely manner. The practice regularly undertook clinical audit, reviewing their processes and monitoring the performance of staff. Staff had received training appropriate to their roles and arrangements had been made to support clinicians with their continuing professional development. The practice worked with other healthcare professionals to share information.

Are services caring?

Good

The practice was rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. For example, 92% of patients felt the GPs treated them with care and concern, compared to a national average of 83%. Patients were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was available for patients to help them understand the care available to them. We also saw staff treated patients with kindness and respect, and ensured confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and arranged the service around this. For example, there was a well defined system for ensuring patients with learning disabilities received regular checks on their health. Patients reported good access to the practice, a named GP and continuity of care, with urgent appointments available the same day. Results from the national patient survey relating to access to the practice were well above national averages. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision which was shared by all staff. There was an effective governance framework in place, which focused on the delivery of high quality care. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients and had a very active patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered personalised care to meet the needs of the older people in its population. The practice had written to patients over the age of 75 years to inform them who their named GP was. The practice was responsive to the needs of older people, including offering home visits.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

The practice had systems to ensure care was tailored to individual needs and circumstances. We spoke with GPs and nurses who told us care reviews for patients with long term conditions took place at six monthly or yearly intervals. These appointments included a review of the effectiveness of their medicines, as well as patients' general health and wellbeing. The practice ensured timely follow up of patients with long term conditions by adding them to the practice registers. Patients were then recalled as appropriate, in line with agreed recall intervals.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

We saw the practice had processes in place for the regular assessment of children's development. This included the early identification of problems and the timely follow up of these. Systems were in place for identifying and following-up children who were considered to be at-risk of harm or neglect. For example, the needs of all at-risk children were regularly reviewed at practice multidisciplinary meetings involving child care professionals such as school nurses and health visitors.

The practice advertised services and activities available locally to families. Lifestyle advice for pregnant women about healthy living, including smoking cessation and alcohol consumption was given by the GPs and midwives.

Summary of findings

Appointments were available outside of school hours and the premises were suitable for children and babies. Arrangements had been made for new babies to receive the immunisations they needed.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group. We saw health promotion material was made easily accessible through the practice's website. This included signposting and links to other websites including those dedicated to weight loss, sexual health and smoking cessation.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable.

Systems were in place in place to identify patients, families and children who were at risk or vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. These patients were offered regular reviews. One of the administration team members took on the role of administering the system and through personal contact built up a rapport with patients and their carers. As a result of this work, 45 out of 46 patients received their annual medical check during the period April 2013 to March 2014.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia).

Summary of findings

Patients experiencing poor mental health had received an annual physical health check. The practice worked closely with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had care planning in place for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. Information and leaflets about services were made available to patients within the practice.

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection. We spoke with people from different age groups, who had varying levels of contact and had been registered with the practice for different lengths of time.

They told us the staff who worked there were very helpful and polite. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were generally happy with the appointments system.

We reviewed 12 CQC comment cards which had been completed by patients prior to our inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided.

The latest GP Patients Survey completed in 2014 showed the large majority of patients were satisfied with the services the practice offered. The results were among the best for GP practices nationally. The results were:

- The proportion of patients who would recommend their GP surgery – 83% (national average 78%)
- GP Patient Survey score for opening hours – 90% (national average 77%)
- Percentage of patients rating their ability to get through on the phone as very easy or easy – 93% (national average 73%)
- Percentage of patients rating their experience of making an appointment as good or very good – 88% (national average 75%)
- Percentage of patients rating their practice as good or very good – 92% (national average 86%).

Areas for improvement

Action the service SHOULD take to improve

The practice should ensure regular checks of the water system for legionella (a type of bacteria found in the environment which can contaminate water systems in buildings) are carried out. We saw a legionella risk assessment had been carried out by the building owners. This highlighted the need to document when checks and flushes of the systems had been performed.

The practice should review its procedures for carrying out fire evacuation drills The last fire evacuation practice was in 2012.

Outstanding practice

The practice was considered to be outstanding in terms of its care of people whose circumstances may make them vulnerable. Specifically, the care for patients with learning disabilities. A member of staff had taken on the role of administering the system, and through personal contact built up a rapport with patients and their carers. As a result of this work, 45 out of 46 patients received their annual medical check during the period April 2013 to March 2014.

Denton Park Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team also included a GP and a specialist advisor with experience of GP practice management.

Background to Denton Park Medical Group

Denton Park Medical Group is located in the West Denton area of Newcastle upon Tyne.

The practice provides services to around 7,100 patients from one location; West Denton Way, West Denton, Newcastle upon Tyne, NE5 2QW. We visited this address as part of the inspection.

The practice is located in a purpose built two storey building; all patient facilities are situated on the ground floor. It also offers on-site parking, disabled parking, a disabled WC, wheelchair and step-free access.

The practice has four GP partners, one salaried GPs, a nurse practitioner, two practice nurses, a phlebotomist, a practice manager, and eight staff who carry out reception and administrative duties.

Surgery opening times at the practice are between 8:00am and 6:30pm Monday to Friday, with extended hours on a Monday evening and Thursday morning.

The practice provides services to patients of all ages based on a Personal Medical Services (PMS) contract agreement for general practice.

The service for patients requiring urgent medical attention out of hours is provided by Northern Doctors.

Why we carried out this inspection

We inspected this service as part of our new 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.

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)

Detailed findings

- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. This did not highlight any significant areas of risk across the five key question areas. As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local Clinical Commissioning Group (CCG).

We carried out an announced visit on 2 December 2014. We spoke with eight patients and 11 members of staff from the practice. We spoke with and interviewed three GPs, the practice manager, two members of the nursing team and five staff carrying out reception and administrative duties. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 12 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe track record

The practice had a good track record for maintaining patient safety.

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how the practice operated. Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards reflected this.

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

Information from the QOF, which is a national performance measurement tool, showed significant events were appropriately identified and reported. GPs told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development. They showed us examples of significant events which had been reported and the subsequent actions taken.

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. 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 and incident reports and minutes of meetings where these were discussed. This 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 was open and transparent when there were near misses or when things went wrong. There was a system in place for reporting, recording and monitoring significant events, incidents and accidents. We asked for and saw records were kept of significant events that had occurred during the past year, and these were made available to us. We found details of the event, steps taken, specific action required and learning outcomes and action points were noted.

Significant events were discussed at the practice's monthly primary healthcare team meetings. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw there had been a significant event in relation to a patient's adverse reaction to some medicines. We saw evidence that a thorough investigation had taken place. This had identified some key learning points, which had been shared with the relevant staff. The changes were implemented and the practice told us they would be reviewed at a later date to confirm they remained effective.

We discussed the process for dealing with safety alerts with the practice manager. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. They told us alerts came into the practice from a number of sources. They were reviewed by one of the GP partners and the practice manager, information was then disseminated to relevant members of staff. The practice manager was able to give examples of recent alerts and how these had been responded to. A record had been kept to indicate when alerts had been reviewed. We were told where safety alerts affected the day-to-day running of the practice; all staff would be advised via an email or in a practice meeting.

Reliable safety systems and processes including safeguarding

We saw the practice had safeguarding policies in place for both children and vulnerable adults. This provided staff with information about safeguarding legislation and how to identify, report and deal with suspected abuse.

There were identified members of staff with clear roles to oversee safeguarding within the practice. The lead GP for safeguarding had recently updated all of the safeguarding policies and worked with staff to ensure they were up to date and well informed about protecting patients from potential abuse.

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Are services safe?

The clinicians discussed ongoing and new safeguarding issues at their weekly meeting, and also held weekly meetings with health visitors. The staff we spoke with had a good knowledge and understanding of the safeguarding procedures and what action should be taken if abuse was witnessed or suspected.

We saw records which confirmed all staff had attended training on safeguarding children and adults. The GPs and Nurse Practitioner had received the higher level of training for safeguarding children (Level 3). Other clinical staff had received Level 2, whilst all other staff attended Level 1 training sessions.

The practice had a process to highlight vulnerable patients on their computerised records system. In previous years the recording of such information had been inconsistent. The safeguarding lead had therefore introduced a new system of checks to ensure all information was correctly 'coded' on the system. This information would be flagged up on patient records when they attended any appointments so that staff were aware of any issues.

The practice had a chaperone policy. We saw posters on display in the waiting room to inform patients of their right to request a chaperone. Staff told us that a practice nurse or a member of the administration team undertook this role. Staff had received appropriate training and were clear about the requirements of the role.

A whistleblowing policy was in place. Staff we spoke with were all able to explain how, and to who, they would report any such concerns. They were all confident that concerns would be acted upon.

Medicines management

There were clear systems in place to manage medicines.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for checking medicines were kept at the required temperatures.

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. Medicines to be used in emergencies were available. We saw records which showed they were regularly checked by one of the practice nurses to ensure they were within their expiry date.

Each of the GPs had a 'doctor's bag' containing medicines for use during home visits. Robust systems were in place to ensure these medicines were in date. The GPs were each responsible for the contents of their own bag; the practice nurse also held records and sent reminders when expiry dates were approaching. We looked at the medicines in two doctor's bags, all of the medicines were in date.

Expired and unwanted medicines were disposed of in line with waste regulations. The practice had an agreement with the adjacent pharmacy to dispose of such medicines daily or as required.

We saw records of the actions taken in response to reviews of prescribing data. For example, patterns of hypnotics (medicines used to treat sleep disorders) prescribing within the practice compared well to other practices in the area. The practice had also identified the prescribing of antibiotics as an area to review, as the data suggested it was prescribing more than other practices in the area. We saw this detailed work was ongoing.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. For example, how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw records of blank prescription form serial numbers were made on receipt into the practice and when the forms were issued to GPs.

Cleanliness and infection control

We looked around the practice and saw it was clean, tidy and well maintained. 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.

One of the practice nurses was the nominated infection control lead. We saw there was an up to date infection control policy and detailed guidance for staff about specific issues. For example, action to take in the event of a spillage. All of the staff we spoke with about infection control said they knew how to access the practice's infection control policies. Infection control training was provided for all staff annually, although not all staff had attended a training course during the current year.

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Are services safe?

The risk of the spread of infection 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 flooring that was impermeable, and easy to clean. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. The privacy curtains in the consultation rooms were changed every six months or more frequent if necessary. We saw the curtains were clearly labelled to show when they were due to be replaced.

The practice had a contract with the owner of the building for cleaning. We looked at records and saw the domestic staff completed cleaning schedules, on a daily, weekly, monthly and annual basis. One of the practice nurses carried out regular infection control audits. We saw records confirming recent checks had been carried out on the sharps bins and the patient toilet areas.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We looked at some of the practice's clinical waste and sharps bins located in the consultation rooms. All of the clinical waste bins we saw had the appropriately coloured bin liners in place and all of the sharps bins we saw had been signed and dated as required.

Staff were protected against the risk of health related infections during their work. We asked the reception staff about the procedures for accepting specimens of urine from patients. They showed us there was a box for patients to put their own specimens in. The nursing staff then wore PPE when emptying the box and transferring the specimens. We confirmed with the nurse practitioner that all clinical staff had up to date hepatitis B vaccinations. We saw there were spillage kits (these are specialist kits to clear any spillages of blood or other bodily fluid) located throughout the building.

The practice was unable to demonstrate that regular checks of the water system for legionella (a type of bacteria found in the environment which can contaminate water systems in buildings) were carried out. We saw a risk assessment had been carried out by the building owners. This highlighted the need to document when checks and flushes of the systems had been performed.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. 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. We saw evidence of calibration of relevant equipment; for example, weighing scales and blood pressure monitoring equipment.

Staffing and recruitment

We saw the practice had an up to date recruitment policy in place that outlined the process for appointing staff. These included processes to follow before and after a member of staff was appointed. We looked at a sample of personnel files. Most staff had worked at the practice for many years but we reviewed the records for the most recently appointed member of staff. We found the appropriate recruitment checks had been completed.

The practice manager and all staff that were in contact with patients had been subject to Disclosure and Barring Service (DBS) checks, in line with the recruitment policy.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff we spoke with were flexible in the tasks they carried out. This demonstrated they were able to respond to areas in the practice that were particularly busy. For example, within the reception on the front desk receiving patients or on the telephones.

Staff told us there was always enough staff on duty to maintain the smooth running of the practice and ensure patients were kept safe. We saw records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

We asked the practice manager how they assured themselves that GPs and nurses employed by the practice continued to be registered to practice with the relevant professional bodies (For GPs this is the General Medical

Good

Are services safe?

Council (GMC) and for nurses this is the Nursing and Midwifery Council). They told us they regularly checked the registration status for the GPs and nurses. We saw records which confirmed these checks had been carried out.

Monitoring safety and responding to risk

Feedback from patients we spoke with and those who completed CQC comment cards indicated they would always be seen by a clinician on the day if their need was urgent.

The practice had developed clear lines of accountability for all aspects of patient care and treatment. The GPs and nurses had lead roles such as safeguarding and infection control lead. Each clinical lead had systems for monitoring their areas of responsibility, such as routine checks to ensure staff were using the latest guidance and protocols.

The practice had well established systems in place to manage and monitor health and safety. The fire alarms and emergency lights were tested on a weekly basis. We saw records confirming these checks had been carried out. We saw the last fire evacuation practice was in 2012. The practice manager said a drill was going to be arranged for the near future.

The practice manager showed us a number of risk assessments which had been developed and undertaken; including a fire and a health and safety risk assessment. Risk assessments of this type helped to ensure the practice was aware of any potential risks to patients, staff and visitors and planned mitigating action to reduce the probability of harm.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had 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). All staff asked knew the location of this equipment.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. A resuscitation trolley was located in the main treatment room. The defibrillator and oxygen were accessible and records of weekly checks of the defibrillator were up to date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather and access to the building. The practice manager and one of the GP partners led on this area. The plans had recently been put into action following a power failure. This meant the temperatures of the medicines fridges were not maintained. We saw staff had followed the appropriate procedures to ensure patients were not put at any risk.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. GPs demonstrated an up to date knowledge of clinical guidelines. There was a strong emphasis on keeping up to date with clinical guidelines, including guidance published by professional and expert bodies. The practice undertook regular reviews of their referrals to ensure current guidance was being followed.

All clinicians we interviewed were able to describe and demonstrate how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners (Newcastle West Clinical Commissioning Group (CCG)).

We found from our discussions with the GPs and nurses that they completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, the practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. We spoke with staff about how the practice helped people with long term conditions manage their health. The practice had a flexible and patient-centred approach. They told us that where patients had a number of different conditions, reviews were carried out within a single nurse appointment where possible. This enabled patients to be cared for holistically, rather than monitored disease by disease.

For some conditions, such as COPD (a lung disease), specialist equipment was required. There were regular clinics where people were booked in for recall appointments. This ensured people had routine tests, such as blood or spirometry (lung function) tests to monitor their condition.

The clinicians we interviewed demonstrated evidence based practice. New guidelines and the implications for the practice's performance and patients were discussed at the weekly clinical meetings.

Interviews with clinical staff demonstrated that the culture within the practice was to refer patients onto other services on the basis of their assessed needs, 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, which led to improvements in clinical care. We saw a number of clinical audits had recently been carried out. The results and any necessary actions were discussed at the primary healthcare team meetings.

Examples of clinical audits included an audit on the use of gliptins (this is a type of medicine used to treat type 2 diabetes). The audit had identified some actions which could lead to improvements in patient care. We found the practice had responded to the issues identified and had updated the protocol for treating patients with diabetes. A second audit cycle was then carried out to assess compliance with the diabetes protocol. This demonstrated an improvement and we saw plans were in place to repeat the audit in 12 month's time.

The practice had also carried out an audit to establish whether it was following guidelines for the management of patients with Atrial Fibrillation (irregular heartbeat). This demonstrated that not all patients had a particular clinical score recorded in their records The practice changed the system for recording such information. A re-audit showed an improvement in the number of patients who had a score recorded.

We reviewed a range of data available to us prior to the inspection relating to health outcomes for patients. These demonstrated that generally the practice was performing the same as, or better than average, when compared to other practices in England. For example, a higher proportion of patients defined as 'at risk' from influenza (63%) had received the seasonal vaccination compared to the national average (52%).

There was one area of risk identified from available data. This related to the prescribing of antibiotics and showed the practice as an outlier compared to national figures. The practice was aware of this, staff told us they thought it may have been related to a higher prevalence of chronic diseases within the practice population. For example, there was a higher proportion of patients with Chronic Obstructive Pulmonary Disease (COPD) compared to national and local averages. Each of these patients had 'rescue antibiotics' at home to help control their conditions.

Good

Are services effective?

(for example, treatment is effective)

The practice had also carried out further research in an attempt to identify the cause of the variation. The CCG had introduced a 'Prescribing Engagement Scheme' to improve quality of patient care, achieve cost-effective prescribing and ensure patient safety. The practice participated in the scheme, had completed an on-line learning tool and was working with a pharmacist to review the prescribing of antibiotics.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support. Once a month the practice closed for an afternoon for Protected Learning Time (PLT). Some of the time during these afternoons was dedicated to training. Some training was also delivered by external experts, for example, fire warden training.

Role specific training was also provided. The practice nurses had been trained to administer vaccines and had attended updates on cervical screening. One of the GPs planned to attend a training course on contraceptive implant fitting to increase their skills and knowledge in that area.

All GPs were up to date with their yearly continuing professional development requirements and all either have 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).

Most other staff had received an annual appraisal. During the appraisals, training needs were identified and personal development plans put into place. Staff told us they felt supported. The practice manager had not received an annual appraisal for some time. We saw this had been noted on the practice action plan and an appraisal had been scheduled for early 2015.

The administrative and support staff had clearly defined roles. Each member of staff was the lead for a particular area. For example, one person was responsible for maintaining the notice boards within the waiting room. They ensured the information was up to date and useful for patients. However staff were also able to cover tasks for their colleagues due to a programme of multi-skilling that was in place. This helped to ensure the team were able to maintain levels of support services at all times, including in the event of staff absence and annual leave.

The patients we spoke with were complimentary about the staff. Staff we spoke with and observed were knowledgeable about the role they undertook.

Working with colleagues and other services

The practice worked closely with other health and social care providers, to co-ordinate care and meet people's needs.

A number of health care services were based in the same building as the practice. This included health visitors and district nurses. In addition, the practice had several 'visiting professionals' such as counsellors, psychologists and physiotherapists. Staff told us they had developed strong links with these services. Although formal arrangements were in place to meet and share information, informal discussions were often held. Staff described many instances where they were able to discuss patient matters with other colleagues when they saw them within the building, rather than always having to send out formal letters. This enabled the practice to provide a more efficient service for their patients.

We saw various multi-disciplinary meetings were held. For example, a weekly primary health care team meeting was held with health visitors and district nurses. Specific safeguarding and palliative care review meetings were held on alternate months. There were well established links with local Macmillan nurses. This helped to share important information about patients including those who were most vulnerable and high risk.

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 hour's provider and the ambulance service.

Correspondence such as blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service, was received both electronically and by post. Information was scanned and passed on to the person who had requested the test (or whoever was covering for them if they were not available). Any urgent correspondence was passed to the

duty doctor to deal with. The GP who reviewed these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained to use the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used electronic systems to communicate with other providers. For example, making referrals to hospital services using the Choose and Book system (the Choose and Book system enables patients to choose which hospital they will be seen in and allows them to book their own outpatient appointments). Staff reported this system was easy to use.

Regular meetings were held throughout the practice. These included all staff meetings, clinical meetings and multi-disciplinary team meetings. Information about risks and significant events were shared openly at meetings. Patient specific issues were also discussed to enable continuity of care.

Consent to care and treatment

Before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. There was a practice policy on consent, this provided guidance for staff on when to document consent.

Staff were all able to give examples of how they obtained verbal or implied consent. We saw where necessary, written consent had been obtained, for example, for minor surgery procedures or contraceptive implants. There was a practice policy for documenting consent for specific interventions.

GPs we spoke with showed they were knowledgeable about how and when to carry out 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. One of the GPs had carried out some personal research on Gillick competencies to enhance their understanding.

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. One of the GPs had attended advanced training and was the MCA 'champion' within the practice. All staff were due to attend MCA training in January 2015. 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 MCA 2005. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment.

Health promotion and prevention

The practice proactively identified people who needed ongoing support. This included carers, those receiving end of life care and those at risk of developing a long term condition. Patients with long term conditions were reviewed each year, or more frequently as necessary.

New patients were offered a 'new patient check', with either a GP or one of the nurses, to ascertain details of their past medical histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g. smoking, alcohol intake, blood pressure, height and weight).

Information on a range of topics and health promotion literature was available to patients in the waiting area of the practice. This included information about screening services, smoking cessation and child health. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. Staff told us about some of the services offered to patients. These included 'exercise on prescription' and access to a local health and wellbeing service. The practice's website also provided some further information and links for patients on health promotion and prevention.

The practice offered a full range of immunisations for children, as well as travel and flu vaccinations, in line with current national guidance. MMR vaccination rates for five year old children were 93.4% compared to an average of 92.7% in the local CCG area and Hib/Men C Booster rates for the same age group were 97.4% compared to an

Good

Are services effective?

(for example, treatment is effective)

average locally of 94.5%. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was 63.1%, this was higher than the national average of 52.3%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with eight patients during our inspection. They were all happy with the care they received. People told us they were treated with respect and were positive about the staff. Comments left by patients on the 12 CQC comment cards we received also reflected this. Words used to describe the approach of staff included caring, friendly, helpful, pleasant and calming.

We looked at data from the National GP Patient Survey, published in July 2014. This demonstrated that patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the practice was well above national and local average scores on the overall experience and the helpfulness of reception staff. We saw that 99% of patients said they had confidence and trust in their GP and 92% said their GP was good at treating them with care and concern.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate, understanding and caring, while remaining respectful and professional.

People's privacy, dignity and right to confidentiality were maintained. For example, the practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination. A private room or area was also made available when people wanted to talk in confidence with the reception staff. This reduced the risk of personal conversations being overheard.

The reception area fronted directly onto the patient waiting area. We saw staff who worked in these areas made every effort to maintain people's privacy and confidentiality. Voices were lowered and personal information was only discussed when absolutely necessary. Phone 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 people's 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

Patients told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given. We reviewed the 12 completed CQC comment cards, they showed patients felt they were involved in their care and treatment. One person commented that staff explained everything and they trusted them. Another person said the doctors always listened and responded to their needs.

The results of the National GP Patient Survey from July 2014 showed patients felt the GPs and nurses involved them in decisions about their care and explained the need for any tests or treatment. Scores for both doctors (85%) and nurses (80%) were well above both the national averages (doctors – 75%, nurses – 67%).

We saw that access to interpreting services was available to patients, should they require it. Staff we spoke with said the practice had very few patients whose first language was not English. They said when a patient requested the use of an interpreter, a telephone service was available. There was also the facility to request translation of documents should it be necessary to provide written information for patients.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice and rated it well in this area. The CQC comment cards we received were also consistent with this feedback. For example, patients commented the GPs and staff knew them well and were caring, reassuring and supportive. The practice routinely asked patients if they had caring responsibilities. They were offered additional support and GPs informed them of a local carer support group.

Notices in the patient waiting room also signposted people to a number of support groups and organisations.

Support was provided to patients during times of bereavement. Families were offered a visit from a GP at these times for support and guidance. Staff were kept

Good

Are services caring?

aware of patients who had been bereaved so they were prepared and ready to offer emotional support. The practice also offered details of bereavement services. Staff we spoke with in the practice recognised the importance of being sensitive to people's wishes at these times.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to the needs of the local population. Patients we spoke with and those who filled out CQC comment cards all said they felt the practice was meeting their needs.

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. There had been very little turnover of staff in recent years which enabled good continuity of care and accessibility to appointments with a GP or nurse of choice. For example, patients could access appointments face-to-face in the practice, receive a telephone call back from a clinician or be visited at home.

Staff told us that where patients were known to have additional needs, such as being hard of hearing, were frail, or had a learning disability this was noted on the medical system. This meant the GP or nurses would already be aware of this and any additional support could be provided, for example, a longer appointment time.

Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the national GP patient survey from 2014 confirmed this. 90% of patients felt the doctor gave them enough time, 91% felt they had sufficient time with the nurse. These results were well above the national averages (86% and 81% respectively).

The practice worked collaboratively with other agencies, regularly updating shared information to ensure good, timely communication of changes in care and treatment. The practice had a palliative care register and had regular internal as well as 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 good, timely communication of changes in care and treatment.

There was information available to patients in the waiting room and reception area, about support groups, clinics and advocacy services.

The practice had a well-established Patient Participation Group (PPG). We spoke with two members of the PPG. They gave us examples of improvements that had been made following discussions between the PPG and the practice. This included extending opening hours and promoting local support groups for carers.

Tackling inequity and promoting equality

The practice had recognised the needs of the different groups in the planning of its services. For example, opening times had been extended to provide early and late appointments each week. This helped to improve access for those patients who worked full time.

Staff at the practice recognised that patients had different needs and wherever possible were flexible to ensure patients' needs were met. One of the GPs told us about the practice's approach to patients with learning disabilities. Each patient was invited to attend an annual medical appointment. However, it was sometimes difficult to reach some patients. One of the administration team members took on the role of administering the system and through personal contact built up a rapport with patients and their carers. The administrator developed records to show which day patients preferred to attend and when they had other commitments. As a result of this work, 45 out of 46 patients received their annual medical check during the period April 2013 to March 2014. The 46th patient subsequently attended in April 2014.

Nationally reported data showed the practice had achieved good outcomes in relation to meeting the needs of patients whose circumstances may make them vulnerable. Registers were maintained, which identified which patients fell into these groups. The practice used this information to ensure patients received an annual healthcare review and access to other relevant checks and tests. One of the nurses specialised in this area, they explained how patients were also offered longer appointment times when necessary.

Free parking was available in a car park directly outside the building. We saw there marked bays for patients with mobility difficulties. The practice building was accessible to patients with mobility difficulties. The consulting rooms were large with easy access for all patients. There was also a toilet that was accessible to disabled patients.

Only a small minority of patients did not speak English as their first language. There were arrangements in place to access interpretation services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The practice is open between 8:00am and 6:30pm Monday to Friday. Evening appointments are available on a Monday until 7:30pm and early morning appointments on a Thursday from 7:00am.

Patients were able to book appointments either by calling into the practice, on the telephone or using the on-line system. Face to face and telephone consultations were available to suit individual needs and preferences. Home visits were also made readily available every day. The practice had a relatively high proportion of elderly patients, and had increased the number of home visits over the past few years to address these patients' needs.

The practice manager told us if a patient wanted an emergency appointment then they could have one the same day. This was confirmed when we observed reception staff taking calls from patients; patients were offered appointments on the same day. If there were no appointments available then a 'task' would be sent via the practice's computer system to one of the GPs (the duty doctor). The duty doctor would then telephone the patient and if necessary ask them to attend the practice later in the day.

The practice was flexible with regard to appointments. They told us they had an 'open door policy', whereby patients were not turned away. Once the routine and urgent appointments were full, there was a daily duty doctor surgery. If any patients phoned the practice for appointments after this time, they were told to go to the practice just before closing time and they would be seen. There was a noticeboard in the waiting room which was updated regularly throughout the day to inform patients if one of the GPs was running late.

All of patients we spoke with, and those who filled out CQC comment cards, said they were satisfied with the appointment systems operated by the practice. Many people commented they were able to get an appointment or speak to someone at short notice. This was reflected in the results of the most recent National GP Patient Survey (2014). This showed 88% of respondents were satisfied with booking an appointment and 90% were satisfied with the opening hours. These results were 'among the best' for GP practices nationally.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The practice's contracted out of hours provider was Northern Doctors.

We found the practice had an up to date booklet which provided information about the services provided, contact details and repeat prescriptions. The practice also had a clear, easy to navigate website which contained detailed information to support patients.

Listening and learning from concerns and 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.

The complaints policy was outlined in the practice leaflet and was available on the practice's website. The practice also had a comments box situated in the entrance foyer to enable patients to provide feedback about the service provided.

None of the eight patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice. In addition, none of the 12 CQC comment cards completed by patients indicated they had felt the need to make a complaint.

Staff we spoke with were aware of the complaints policy. They told us they would deal with minor matters straight away, but would inform the practice manager of any complaints made to them. Patients could therefore be supported to make a complaint or comment if they wanted to.

We saw the summary of complaints that had been received in the 12 months prior to our inspection. A summary of the complaint, details of the steps taken, the outcome of the investigation, and details of any contact with the complainant were recorded. The method by which the practice was informed of the complaint was also recorded and we saw that verbal indicators of dissatisfaction were investigated.

The practice had a robust approach to dealing with complaints in that all complaints were discussed at the full

Good

Are services responsive to people's needs?

(for example, to feedback?)

team meetings so that any wider issues that needed to be addressed were shared. There was a 'no blame' culture. Complaints were anonymised, with patients and staff not being named, so that discussion could be open and frank. Staff we spoke with felt involved in the process.

We looked at the most recent complaints the practice had received. We saw these had all been thoroughly investigated and the complainant had been communicated with throughout the process. We found the practice listened and learned from the complaints. For example, following one complaint we saw some staff had attended further training courses.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's aims and objectives. The practice had a mission statement which had been shared with patients and staff. The mission statement made reference to providing high quality health care, the professional development of team members and continuous evaluation of care to meet future challenges.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They all told us they put the patients first and aimed to provide person-centred care. We saw that the regular staff meetings helped to ensure the vision and values were being upheld within the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. These were available to staff via the shared drive on any computer within the practice. All of the policies and procedures we looked at had been reviewed regularly and were up-to-date.

There was a management team in place to oversee the practice. The practice held regular governance meetings where matters such as performance, quality and risks were discussed. The practice used the Quality and Outcomes Framework (QOF) as an aid to measure their performance. The QOF data for this practice showed it was performing above the averages of the local Clinical Commissioning Group (CCG) and across England as a whole. Performance in these areas was monitored by the practice manager and GPs, supported by the administrative staff. We saw that QOF data was discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice manager and GPs actively encouraged staff to be involved in shaping the service.

We found that staff felt comfortable to challenge existing arrangements and looked to continuously improve the service being offered.

Staff told us they were aware of the decision making process. For example, staff who worked within reception demonstrated to us they were aware of what they could and couldn't do with regards to requests for repeat prescriptions.

The practice had completed a number of clinical and internal audits. For example, a clinical audit on the management of patients with atrial fibrillation (irregular heartbeat) and an internal infection control audit. The results of these audits and re-audits demonstrated outcomes for patients had improved.

The practice manager and GPs told us forward planning was discussed regularly. The practice manager had developed an action plan for the forthcoming year. This was regularly reviewed and updated and included plans to carry out an audit of the appointments system, an analysis of capacity and demand and invite external speakers to staff meetings.

Leadership, openness and transparency

The practice had a clear leadership structure designed to support transparency and openness. There was a well-established management team with clear allocation of responsibilities. The GPs all had individual lead roles and responsibilities, for example, safeguarding, risk management, performance and quality. We spoke with 11 members of staff and they were all clear about their own roles and responsibilities. Managers had a good understanding of, and were sensitive to, the issues which affected patients and staff.

Staff told us there was an open culture in the practice and they could report any incidents or concerns they might have. This ensured honesty and transparency was at a high level. We saw evidence of incidents that had been reported, and these had been investigated and actions identified to prevent a recurrence.

Staff told us they felt supported by the practice manager and the clinical staff and they worked well together as a team. We saw from minutes that team meetings were held regularly. Some staff worked part-time hours. We saw the same meeting was held on two different days which allowed all staff to attend. The practice manager told us a full team 'away day' was planned for early 2015.

Are services well-led?

Good

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

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

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff we spoke with told us their regular meetings provided them with an opportunity to share information, changes or action points. They confirmed they felt involved and engaged in the running of the practice.

The practice had an active patient participation group (PPG), with around 11 members. The PPG contained representatives from various population groups and was actively trying to increase representation from the younger population. The PPG met every quarter and a representative from the practice always attended to support the group.

The practice carried out an annual patient satisfaction survey over a two week period. The PPG had been involved in the development of the survey. Members were consulted about the questions to include in the survey and discussed the results. The results and analysis from the survey were available on the practice website. We spoke with some members of the group and they felt the practice supported them fully with their work and took on board and reacted to any concerns they raised. For example, increasing awareness about support available for carers. We saw there was a dedicated noticeboard in the waiting room with information for carers.

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 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. We saw plans were in place to carry out a benchmarking exercise with other local GP practices during early 2015.

The practice had robust whistleblowing procedures and a detailed policy in place. Staff we spoke with were all able to explain how they would report any such concerns. They were all confident that concerns would be acted upon.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance.

Staff told us that the practice was very supportive of training. They said they had received the training they needed, both to carry out their roles and responsibilities and to maintain their clinical and professional development. We saw that regular appraisals took place. Staff from the practice also attended the monthly CCG protected learning time (PLT) initiative. This provided the team with dedicated time for learning and development.

The practice had a robust approach to incident reporting in that it reviewed all incidents The management team met monthly to discuss any significant incidents that had occurred. The practice had completed reviews of significant events and other incidents and shared these with staff. Staff meeting minutes showed these events and any actions taken to reduce the risk of them happening again were discussed.

The practice manager met monthly with other practice managers in the area and shared learning and experiences from these meetings with colleagues. GPs met with colleagues at CCG meetings. They also attended learning events and shared information from these with the other GPs in the practice.