Brotton Surgery

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 an announced comprehensive inspection at Brotton Surgery on 2 May 2015. Overall the practice is rated as good. Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the 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 and people experiencing poor mental health (including people with dementia). We found the care of older people to be outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- 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 management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

Summary of findings

The practice provided medical cover for the local community hospital beds. Where they were able to admit, transfer and manage their own patients. The practice also worked in partnership with the local consultant Geriatrician in the management of patients in the community hospital. The GPs and consultant Geriatrician had admitting rights to the community hospital beds. This also facilitated access to the expertise of the consultant in managing their patients. They were also able to refer and manage patients as part of the virtual ward managed by the community matron. The community matron was not employed by the practice.

Action the provider SHOULD take to improve:

The checking process for controlled medication was incomplete.

The cleanliness of the medicine cupboard was not monitored.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to 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 was enough staff to keep people safe. Risks to patients were assessed and well managed. All the staff we spoke with were knowledgeable and aware of their responsibilities in maintaining patients and visitors safety.

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. National Institute for Health and Care Excellence (NICE) guidance is referenced and used routinely. Patients' needs were assessed and care planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff received training appropriate to their roles and further training needs had been identified and planned. We saw that regular staff appraisals were undertaken and all staff were aware of their roles and responsibilities. We saw evidence of good multidisciplinary working, links to local community groups and to the community hospital where the practice worked jointly with the Geriatrician. A Geriatrician is a doctor who specialises in the care of the elderly.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that 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. It reviewed the needs of its local population and engaged with the NHS Area Team to secure improvements to services where these were identified. The practice was part of a local GP federation which worked together with other practices sharing responsibilities for delivering high quality care to their local communities.

Summary of findings

Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, 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 the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for providing well-led services . It had a clear vision and strategy. Staff were clear about 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 and held regular governance meetings. There were systems in place to monitor and improve quality and identify risks. The practice proactively sought feedback from staff and patients, which it acted on. The practice were in the process of establishing a patient participation group (PPG) with 10 members recruited. Staff had received inductions, regular performance reviews and attended staff meetings and events. There was active staff development and team programmes to ensure all staff were involved in practice developments and worked pro-actively as a team.

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

Outstanding ☆

The practice is rated as outstanding for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people and had a range of enhanced services, for example, in dementia and end of life care.

The practice provided a community service into the elderly care ward of the local community hospital which was housed in the community hospital attached to the surgery. The practice worked with the consultant Geriatrician from the local acute hospital. The GPs were able to admit and manage their own patients from home or manage their patients who were transferred from the local acute hospital which helped patients integrate back into the local community. The patients had care plans in place to ensure they were managed and unplanned admissions were avoided.

The use of the community beds meant that patients could be managed closer to home. The practice area is around twenty five miles distance from the nearest acute hospital. Many of the local people rely on public transport which is difficult to access for those living in rural areas.

We saw evidence of good links to the community matrons, and local support groups. The practice was also involved in the virtual ward scheme. The virtual ward provided support in the community to people with the most complex medical and social needs and was overseen by the community matrons. The practice also linked with and recommended patients to several support groups in the area for elderly people. Examples of these were: over 60 s lunch club, the woman's institute and the university of the third age based in Saltburn.

The practice consistently reached the national average for flu vaccination each year proactively and opportunistically promoting this to their patients. The practice worked in partnership with the neighbouring GP practice to identify patients across both GP lists and sort these into postcode areas. This enabled the practice to identify geographical areas where patients from either area were based. The practices then employed locum nurses to deliver the vaccines to patients in their own homes and held clinics during the

Summary of findings

day and evenings. This ensured housebound patients had access to the vaccination. The clinics had pre bookable appointments, where five clinicians worked together to administer the flu vaccines within the practices.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. These patients had a named GP and a structured annual review to check their health and medication needs were being met. For those people with the most complex needs, the named GP, nurse practitioner or practice nurse worked with relevant health and care professionals to deliver a multidisciplinary package of care. Each patient on the palliative care register list were assigned a named GP to oversee their individual care. This was discussed at regular multi-agency palliative care meetings. The practice nominated a lead GP in this area who had extensive experience in hospice and end of life care.

The practice regularly monitored patients with long term conditions and proactively followed up these patients following hospital admissions to prevent re admissions and support recovery.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. It included children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

We saw good examples of joint working with midwives, health visitors and school nurses.

Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly. The practice offered a full range of family planning services at the practice. The uptake of cervical screening was above the national average. Patients were able to access these services at a time that suited them.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The 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 that reflected the needs for this age group. Patients are able to book appointments twenty four hours a day using the practice automated system. The practice offered early morning and evening appointments for those patients who have to commute to and from work. Improving access for this patient group. The practice regularly monitored patients' satisfaction for access to appointments which currently demonstrated a high level of satisfaction.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. They had carried out annual health checks for patients with a learning disability and when required they had received a follow-up appointment. Longer appointments were available for patients with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The next of kin and named carer details were recorded visibly in the patient's notes to ensure all staff could access this information quickly. 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 normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had recently started to offer dementia screening within the practice to identify any problems; proactively referring patients to the memory clinic when appropriate. The practice worked closely with the mental health crisis team who responded quickly to patients' needs.

The practice had told patients experiencing poor mental health how to access various support groups and voluntary organisations. There

Summary of findings

was a system in place to follow up patients who had attended accident and emergency (A&E) where they had been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia. The reception staff followed a non-clinical triage assessment system of the patient when booking appointments for this patient group. They were able to offer longer and same day appointments where necessary.

Summary of findings

What people who use the service say

We received 21 completed CQC comment cards. We spoke with eight patients who were using the service on the day of inspection. We spoke with a range of patients from different age groups and with different health needs. We also spoke with one member of the newly established patient participation group. All the patients we spoke with were complimentary about the service. They told us they found the staff to be caring, supportive, and provided them with consistently high levels of care.

Patients were aware they could have someone present at their consultation if required and were able to speak to staff in a private area if necessary. All patients spoken with were happy with the cleanliness of the environment and the facilities available.

We saw that the practice was continually seeking feedback from patients to shape and develop services in the future. The practice had a suggestion box available in reception where patients could leave their comments and suggestions. The practice produces a regular newsletter for patients that provided useful information, news and developments in the practice. Examples of these were the number of missed appointments, online services, staff changes and developments.

The practice undertook a General Practice Assessment Questionnaire GPAQ 2015 survey, completed by 150 patients. This showed the practice performed well against the national average in most areas. For example:

- 75%of respondents were satisfied with the opening hours: the national average: 67%
- 71% of respondents were satisfied with the availability of the GPs and nurses: the national average:69%
- 92% of respondents were satisfaction with how well GPs and nurses listens to them: the national average:84%
- 93% of respondents were satisfaction with how well GPs and nurse puts patient at ease: national average:84%

We also saw there were some areas the practice could improve upon. The practice reviewed the results and developed an action plan for the areas which they were at or below the GPAQ average. This gave them two areas only. The practice deemed this insufficient and decided to include another six areas where the average score was below 70%. This gave them another six areas. For example the ability to keep healthy after visiting the doctor and improving satisfaction with opening hours. The action plan also identified who was responsible for the action and when the action would be reviewed. This ensured the practice continually reviewed how they were meeting the actions and improving services.

The practice had recently developed a patient participation group (PPG). The PPG had their first planned meeting shortly following our inspection. The practice manager had been meeting and speaking with the members to prepare them for this role.

We found the practice valued the views of patients and saw following feedback from surveys changes were made in the practice. They had also reviewed when the demand for appointments were highest and had adjusted staff work schedules to ensure they were available to respond to the demand.

Areas for improvement

Action the service SHOULD take to improve

The checking process for controlled medication was incomplete.

The cleanliness of the medicine cupboard was not monitored.

Summary of findings

Outstanding practice

We saw the practice was outstanding in the provision of care of older people. The practice provided clinical input into the local community geriatric ward based in the Community hospital attached to the surgery. The practice was able to admit and manage their patients direct from home or transferred from the acute hospital. This allowed the patients to receive care closer to home provided by GPs who knew them and enabled them to stay closer to their family and friends. The practice was also involved in referring and supporting patients managed at home, as part of the virtual ward scheme. A virtual ward provided support in the community to people with complex medical and social needs and was managed by community matrons.

Brotton Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, a GP specialist adviser, CQC inspector and a specialist practice manager.

Background to Brotton Surgery

Brotton Surgery delivers general medical services (GMS) under a Contract between themselves and NHS England. They are part of a local GP federation with other practices in the area.

There are four GP partners and currently they have one long term locum. The locum GP is currently covering some long term GP absence. There are two female and two male GPs and the locum GP is female. The practice delivers services to the East Cleveland area with the majority of patients coming from Brotton, Loftus and Skelton. They provide services to 6,100 patients of all ages. The practice population increased by 600 in 2014 due to the closure of a local practice. The practice responded by increasing the nursing and administrative staff to allow them to cope with the expanding demand. The practice area is roughly around twenty five miles from the nearest acute hospital. We saw that the practice were able to admit and manage patients transferred the community hospital a service patients told us they valued.

The practice is a teaching practice and in the week of our inspection they were informed they have also become a training practice. There were no GP registrars or medical students working in the practice on the day we visited.

Patients can book appointments face to face, by the telephone or online. The practice treats patients of all ages and provides a range of medical services. The practice GPs do not provide an out-of-hours service to their own patients and patients were signposted to the local out-of-hours service via 111 when the surgery is closed and at the weekends. In emergency patients were advised to ring 999 or attend the nearest accident and emergency department. The out of hour's provider for the area is Northern Doctors Urgent Care (NDUC).

There is an all-female nursing team of one nurse practitioner and two practice nurses. The team are supported by two phlebotomists. The nurses promote healthy living; provide support for patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD).

The practice has car parking facilities and access for the disabled. The practice recently fitted an automated door making entering and leaving the practice easier for those with disabilities. There are links to public transport. There were no previous performance issues or concerns about this practice prior to our inspection.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act as part of our regulatory functions. This inspection was planned to check whether the provider was 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 our inspection we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We asked NHS North East and the Local Healthwatch to tell us what they knew about the practice and the service provided. We reviewed some policies and procedures and other information received from the practice prior to the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We carried out an announced inspection on 2 April 2015. During our inspection we spoke with the staff available on the day. This included two GPs, two practice nurses, the practice manager, and three administration staff. The nurse practitioner was not available on the day of the inspection but we spoke with her following the inspection by phone. We also spoke with eight patients who used the service and one member of the patient participation group.

We reviewed 21 CQC comments cards which had been completed where patients shared their views and experiences of the service. We observed the interaction between staff and patients in the waiting room.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, report incidents and near misses. For example the practice had a specific process to raise safety concerns and all issues raised were investigated.

We reviewed safety records, incident reports and minutes of meetings where these were discussed over the last year. This showed the practice had managed them consistently over time and so showed evidence of a safe track record over the long term. We saw learning and improvement from safety incidents.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the year and we were able to review these. Significant events were a standing item on the practice

clinical meeting. We saw regular review of actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. We saw there had been 16 significant events recorded from 2014 until April 2015. All staff we spoke with knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. Staff told us they would always raise any concerns or risks with the practice manager or one of the management team.

We saw the practice had a nominated safety lead that monitored safety and risk within the practice. We saw evidence of action taken as a result of an issue raised. An example of this was reviewing confidentiality and ensuring computers were moved so patients could not view information when they were standing at the reception desk.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at staff meetings to ensure all staff were

aware of any that were relevant to the practice and where they needed to take action. An example given by staff was the recent Ebola information.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all staff had received relevant role specific training on safeguarding and the mental capacity act. We asked members of the medical,

nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in and out of normal hours working hours. Contact details were easily accessible on the practice computer system. The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children and a nominated deputy. They had been trained at level three and could demonstrate they had

the necessary training to enable them to fulfil this role. The lead was aware of all safeguarding concerns raised within the practice. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. The practice was able to identify families, children, and young people living at risk or in disadvantaged circumstances, and looked after children. The clinical staff confirmed they were able to identify and follow up children, young people and families. There were systems in place for identifying children and young people with a high number of A&E attendances. Child protection case conferences and reviews were attended by staff where appropriate. We were told that children who persistently fail to attend appointments for childhood immunisations would be followed up with letters and discussed with the Health visitor.

The practice had regular staff meetings to discuss urgent concerns regarding patients.

Good

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. We saw that staff were aware of and responsive to older people, families, children and young people, vulnerable people and the support they may require. The practice had good awareness of the support organisations within the local community and surrounding areas. The lead safeguarding GP was aware of vulnerable children and adults and demonstrated good liaison with partner agencies such as the police, social services and support organisations.

There was a chaperone policy, and chaperone notices which were visible on the waiting room noticeboard and in consulting rooms. All nursing staff had been trained to be a chaperone.

The practice had processes in place to identify and regularly review patients' conditions and medication. There were processes to ensure requests for repeat prescribing were monitored by the GPs.

Medicines management

We checked medicines stored in the practice and medicine refrigerators and found they 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, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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.

The nurses and the GPs administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these and evidence that nurses had received appropriate training to administer vaccines.

The nurse practitioner was qualified as an independent prescriber and she received regular supervision and support in her role; as well as updates in the specific clinical areas of expertise for which she prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. Medicines that were liable to misuse, called controlled drugs, were stored appropriately. However the checking process for controlled medication required improvement. The register was not checked by two people on a regular basis. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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

We saw a system was in place for managing national alerts about medicines such as safety issues. Records showed the alerts were distributed to staff, who implemented the required actions as necessary to protect people from harm.

Cleanliness and infection control

We observed the premises to be clean and tidy. The decoration within the building was in need of re decoration and improvement. The practice showed us plans they have for redecoration. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. However the exception to this was the dust found on shelves in the Medication cupboard which was kept locked.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received awareness of infection control specific to their role and received annual updates. We saw evidence that the lead had carried out regular audits and any improvements identified for action were completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy. There

was also a policy for needle stick injury and staff were aware of the action to take in this event. We saw that following such an incident the correct process had been followed and staff were more vigilant.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had 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. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and patient monitoring equipment were regularly tested.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and where indicated criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We saw that two of the nurses who had been employed for ten and twenty five years had not had a DBS check since being employed at the practice. We discussed this with the practice manager. Since our visit we received information that DBS checks had been completed.

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 to ensure that enough staff were on duty. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager continually monitored the staffing levels to ensure staffing levels and skill mix was in line with planned staffing requirements. We were told that currently the practice had some long term GP sickness and the practice was addressing this with a long term locum GP. We saw that they are continually reviewing this to ensure patient access to services was appropriate.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and a named health and safety lead. Health and safety information was available to staff on the practice computer system. The staff we spoke with were aware of this. Identified risks were included on a risk log. Risks were assessed and mitigating actions recorded to reduce and manage the risk. We saw that risks and concerns were discussed at the practice meetings. For example we saw that following a recent fire assessment visit by the fire safety team who had identified that the number of leaflets and posters on walls should be reduced. Following their visit the number of leaflets and notices in the waiting area and on walls had been reduced to mitigate the risk of fire. We saw the practice had ensured information for patients was available in the GP consulting rooms for GPs to print out as and when required reducing the number of leaflets in the waiting areas.

Staff were able to identify and respond to the changing risks to patients including deteriorating health and well-being or medical emergencies. We saw for all patients with long term conditions there were emergency processes in place to deal with their changing conditions. The nurses we spoke with told us that if a patient's condition was deteriorating they would increase the

frequency of appointments and discuss with the named GPs. We saw that were there were concerns about a patient's condition they could be discussed and advice obtained from other clinicians, immediately. We saw that there were regular meetings held in the practice and that the GPs and nurses met up to discuss issues daily over a planned coffee break.

Good

Are services safe?

There were emergency processes in place for identifying acutely ill children and young people, and staff gave us examples of referrals they had made. The practice had appropriate equipment in place to deal with medical emergencies for all patient groups.

We saw information on the practice web site and in the waiting areas explaining what patients who are experiencing a mental health crisis should do to access emergency care and treatment. The practice also provided a room three times a week where counselling sessions were held. This meant patients did not need to travel long distances and could receive support close to home. We saw there were close links to community support and the mental health trust.

The clinical staff told us they actively assessed patients for dementia to ensure they were diagnosed and offered the treatment and support they required. Patients diagnosed with Dementia were offered an appointment with a GP to discuss and agree a care plan that met their needs. The practice also demonstrated the close working relationship with the consultant Geriatrician who provided input into the local community hospital beds.

The practice monitored repeat prescribing for people receiving medication for mental health needs and this was scheduled as part of their annual review. We saw that education sessions had been held to raise awareness of GPs to avoid dependence of certain medication in patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The staff we spoke with were confident about dealing with emergencies. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. 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. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of which heating and electricity company to contact if the power failed.

The practice had carried out a fire risk assessment it included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

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 approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from NICE and from local commissioners. We saw evidence that where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure each patient received support to achieve the best health outcomes for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. We saw evidence that GPs and nurses had processes in place to continually update their knowledge and skills. Examples of these were attending the Clinical Commissioning Group (CCG) education sessions and attending external courses. The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. The practice nurses provided daily access in these areas and patients were able to book directly with the nurse. For example, for appointments for asthma and diabetic reviews. We saw that the nurse practitioner had changed her working days to ensure she was available when the demand from patients was at its highest. This helped to ensure the practice was continually responding to their patients' needs by improving access to services. We saw that a nominated GP attended the CCG meetings on behalf of the practice.

The practice undertook an internal peer review of referrals and also bench marked this with the neighbouring practices. We saw that care plans had been developed for patients with complex needs. These were reviewed at the practices clinical and multidisciplinary meetings and when required. National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The practice used a referral system to refer patients into secondary care. We saw the practice had a system in place to ensure good compliance with this system. We saw there were processes in place for patients with suspected cancers who were referred to secondary care were seen within two weeks.

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

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and the GP partners to support the practice to carry out clinical audits.

The practice had a comprehensive audit record and most of the audit cycles had been completed. We looked at two clinical audits that had been undertaken in the last two years. The two audits we looked at were, Contraception Prescribing in patients seeking Emergency Contraception and Minor Operations. The first audit was undertaken following new advice released by the Faculty of Sexual and Reproductive Health. The guidance advised that ongoing contraception should be given at the same time as patients taking emergency contraception. We saw that two cycles had been completed and a third was in progress. The purpose of the second audit was to evaluate whether or not minor operation histology results were actioned appropriately.

We saw that the practice had taken action following these audits. For example following the audit of contraception advice the practice now fitted many more Long Acting Reversible Contraceptives to patients and this helped to reduce the numbers of patients attending for emergency contraception. The practice was able to demonstrate an increase in patients given concurrent contraception from 35% to 69.3%. This also helped raise awareness with GPs to follow new guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts, and significant events or as a result of information from the quality and outcomes framework (QOF). The QOF is a

Good

Are services effective?

(for example, treatment is effective)

national performance measurement tool. The practice demonstrated a high performance rate in achieving QOF well above the local and national average. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the percentage of patients with diabetes, on the register, who had, had influenza immunisation, was 99%. The practice met all the minimum standards for QOF in diabetes/ asthma/ chronic obstructive pulmonary disease (lung disease) and dementia. This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical research, and clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be

improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

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. We saw that each palliative care patient was managed by a nominated GP who monitored their care needs and

treatment. The practice participated in local benchmarking. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This

benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with a number having additional diplomas or qualifications. Examples of these were palliative care, sexual health reproductive medicine, teaching medical students and the training of GP registrars. All GPs were up to date with their annual continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. The practice was also commencing 360° appraisals for not only GPs but also for the nursing staff. The 360° appraisal is a process of facilitated self-review supported by information gathered from the full scope of the clinicians work such as other colleagues and patients. In February 2015 the practice undertook 25 patient satisfaction surveys for each of the GPs and nurses as part of obtaining personal feedback. This allowed the clinicians to understand their effectiveness in communication and how they might improve the quality of their professional work.

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses for staff. An example was the training of the nurse practitioner. The practice had recently employed a new nurse who had moved from secondary care(hospital) to work as a practice nurse. We saw that the nurse had a programme of training and development and support. This ensured they were provided with the skills required to fulfil their role.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, administration of vaccines and cervical cytology. Those with extended roles seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease) were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed staff received regular reviews and support and that where poor

performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. They received blood test results, x-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the

Good

Are services effective?

(for example, treatment is effective)

responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw 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. We saw that changes to staffing who visited the practice were detailed in the practice newsletter. Examples of these were the changes in personnel to the practice pharmacist and midwives. The practice also alerted patients when staff roles changed. We saw in the patient's newsletter that the Health visitor would no longer be undertaking childhood immunisations and this would now be undertaken by one of the practice nurses.

The practice was commissioned for several enhanced service. Examples of these were flu vaccinations, dementia and warfarin monitoring. We saw that the practice had systems in place to manage and learn from unplanned admissions. Enhanced services required an enhanced level of service provision above what is normally required under the core GP contract. We saw that the practice had developed policies and procedures to deal effectively with the enhanced services and regularly monitored their performance.

The practice held multidisciplinary team meetings every six to eight weeks to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider to enable patient data to be shared in a secure and timely manner. Staff reported that this system was easy to use.

The practice had also signed up to the electronic Summary Care Record. The practice had in place a medical records system which allowed the clinical and the patients' care teams instant access to medical records at this surgery. This system enabled staff in the practice to see and treat patients within the practice. These records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours. The practice had systems in place to provide staff with the patient information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospitals, to be saved in the system for future reference. Hospital discharge letters were mainly electronic and were coded and seen by a doctor. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had processes in place to help staff, for example with making do not attempt resuscitation orders. This highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). The staff we spoke were able to give examples of how a patient's best interests were taken into account if a patient did not have capacity to make a certain decision on the day.

All clinical staff demonstrated a clear understanding of Gillick competencies. These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. One of the GPs we spoke with explained that they taught the Gillick competency at the local university to medical students.

Good

Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions. For example, for all surgical procedures consent was recorded. The practice also followed implied and verbal consent given by patients and recorded this in the patients' medical record.

The practice had not needed to use restraint in the last three years, staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice asked new patients to complete a new patient registration form. The practice would then invite patients in for an assessment with one of the clinical staff. The registration form is detailed. This ensured the practice had up to date information about the patient, their treatment requirements and details of their family history. The GPs were informed of all health concerns detected and these were followed up in a timely manner.

We were told that GPs and nurses use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic screening to

patients, offering health promotion advice such a weight management and smoking cessation. The practice had developed a health promotion policy to ensure staff were aware of their responsibilities. The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were offered an annual physical health check. Similar mechanisms of identifying 'at risk' groups were used for patients who were receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 85% which was above the national average of 77%. Performance for national chlamydia, mammography and bowel cancer screening in the area were all above average for the CCG and a similar mechanism of following up patients who did not attend was used for these screening programmes. When we visited the practice it was national bowel cancer awareness week and we saw information in the practice promoting awareness to patients.

The practice offered a full range of immunisations for children, travel and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders in the practice, these were also discussed with the Health Visitors.

The practice kept a register of patients who were identified as being at high risk of admission, or at End of Life and had up to date care plans in place for sharing with other providers. All patients on the practice 'at risk 'group were offered appointments with their named GP to discuss and agree their care plans. Patient care plans were reviewed regularly to ensure they continued to meet the patient's needs. We saw that following the GP long term sickness of the GP lead for end of life care the practice had identified that this was not being picked up within the practice. In response to this they identified it as a significant event and reviewed the process and meetings to ensure they were scheduled effectively to meet the patients' needs.

The practice staff met regularly to review patients' admissions to hospital and Accident and Emergency to establish if anything could have been done to prevent attendance. We saw that patients in this group were followed up after admissions and the practice used resources available to prevent readmission. Examples of this were the use of the virtual ward with the community matron. We saw patients received regular structured annual medication reviews for polypharmacy. Monthly audits of patients on repeat prescribing were undertaken and distributed to each GP to ensure they were alerted to patients who required an annual review, follow up tests such as bloods and blood pressure monitoring.

All patients over 75 had a named GP. People with long term conditions received a structured annual review for various long term conditions (LTC). Examples of these were Diabetes, COPD, Asthma and Heart failure. The percentage of patients with diabetes, on the register, who had their cholesterol measured within the preceding 12 months, was 90% which was above the national average of 81%.

We saw good information provided in the practice and on the practice web site. We did not see links to health promotion on the NHS Choices site on the practice web site. Nor access to a range of assessments such as alcohol and depression screening which could provide more information to patients' understanding of their condition.

Good

Are services effective?

(for example, treatment is effective)

We saw that the practice regularly reviewed and monitored patient records using the electronic patient records. Examples of these were monitoring new cancer diagnoses, annual reviews with medicines management and cervical screening final non responders. We saw that the practice regularly monitored the palliative and safeguarding registers which were discussed at the clinical and multidisciplinary management meetings.

There were comprehensive screening and vaccination programmes which were managed effectively to support children and young people. Staff were knowledgeable about child protection and safeguarding. The practice had processes in place to monitor any non-attendance of babies and children at vaccination clinics and worked with other agencies to follow up any concerns.

The practice provided services that were accessible to working age people. The practice offered services up until 5.00 pm Monday to Friday. The practice also offered commuter appointments from 7.30 am and 5.30pm for those patients who were commuting to and from work and required an early morning or later appointment. Patients could also access appointments with the nurse practitioners.

We saw that the practice were aware of people whose circumstances may make them vulnerable. The practice held registers of patients in various vulnerable groups such as learning disabilities. People experiencing poor mental health in the practice had access to services. We saw that patients with severe mental health problems received an annual physical health check.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the General Practice Assessment Questionnaire (GPAQ) 2015, which was undertaken in the practice. The practice had ensured that 25 questionnaires were completed for each of the GPs and nurses making a total of 150 completed questionnaires. This enabled the practice to receive feedback regarding individual clinicians and identify any actions that may be required to improve services. The practice had a box for patients to leave comments and suggestions in the reception area.

The evidence from all these sources showed patients were generally satisfied with how they were treated and that this was with professionalism, compassion, dignity and respect. For example, data from the GPAQ 2015 showed 75% of patients were satisfied with the practice's opening hours which was above the national average of 67%. It also showed that 71% of patients were satisfied with the availability of the GPs and nurses, the national average was 69%.

We saw that following patient surveys the practice had produced and agreed an action plan and priority areas for the year. Examples of these priority areas were improving satisfaction with phoning through to the practice, helping patients to keep healthy after visiting the doctor and improving satisfaction with opening hours. There were two areas identified where the practice were at the national average. The practice felt there were also other areas where they could improve and agreed to action any results where the average score was below 70%. This gave the practice another six areas making a total of eight actions for the coming year. We looked at the action plan and found a detailed plan for each action identified many of which had been completed. For example, an audit of actual waiting time, from time of appointment and an audit of patient waiting time from time patient arrived at the surgery. This corresponded to the question about the satisfaction of waiting times and established a view of the current waiting times experienced by patients.

Patients completed CQC comment cards to tell us what they thought about the practice, we received 21 completed cards. All but one of the comments we received were positive about

the service patients experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with eight patients on the day of our inspection and one members of the PPG. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located behind reception and staff were careful to ensure calls could not be overheard by patients at the desk. The reception area was small and the desk was set back a little from the patient waiting area. Patients were encouraged to wait to allow only one patient at a time to approach the reception desk. This helped to prevent patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. The staff told us that for those patients who did not want their name displayed on the Jayex board in the waiting area a note would be entered onto their patient records. An example given to us was patients visiting the midwife.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff and the business management team.

Good

Are services caring?

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 89% of patients were satisfied with how much the GP or nurse involved the patient in their care which was above the national average of 81%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us they were able to access translation services for patients who did not have English as a first language. The practice had a low level of patients requiring translation service.

The practice had developed care plans for older people and those identified at risk such as those with Long Term Conditions. We were told that changes in these patients were continually reviewed and the community support team were involved as required. The clinicians were able to discuss any concerns with other clinicians outside of the clinical meetings at the informal coffee break held each day with clinicians.

We saw that families, children and young people were treated in an age-appropriate way and recognised as individuals.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the support provided by the practice and rated it well in this area. We saw that the practice sign posted patients to local support services such as luncheon clubs in the area. The patients we spoke to on the day of our inspection and the comment cards we received told us they were supported by the staff. For example, these highlighted that staff responded compassionately and positively when they needed help and provided support when required.

The practice also provided and made available information for patients about how to access a number of support groups. There was information available for carers to ensure they understood the various avenues of support available to them. The practice held carers register and asked new patients registering with them if they were a named carer for anyone.

Staff told us that if families had suffered bereavement, they tried to follow these up particularly following end of life pathway. The staff working in the practice knew their patients well and the staff turnover in the practice was minimal. This meant the staff were able to build up a relationship with patients and be aware of issues that may affect them in the local community.

The practice recognised isolation as a risk factor for older patients. There was information which promoted local groups. We saw that people suffering with long term conditions received regular annual reviews and if appropriate they were reviewed more regularly. From the comments we received patients told us they felt supported and had access to services. The staff were aware of depression that may accompany these conditions and had services that could be accessed within the practice four days a week.

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 was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS Area Team and CCG told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice were also part of a local GP federation which they referred to as an alliance. We saw the minutes from meetings where changes and developments had been discussed and actions agreed to implement service improvements and manage delivery challenges. Examples of these were the appointment of a permanent locum and another practice nurse to assist with the long term GP absence and the increase of patients.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback receive from patients. We saw that they had developed an action plan for 2014 /15. Examples of these were making available early morning and evening appointments for working patients who commuted.

We saw a suggestion box in the reception areas and were told that the practice intended to develop a separate notice board for the PPG. The PPG is currently in the early development stages and the practice have been providing support to the members to enable them to fulfil this role. The practice had started to produce regular newsletters which provided a range of information to patients and informed them of changes to staffing and practice developments.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. They recognised those with a learning disability, students, carers and the older population. The practice had access to translation services and all staff were aware of how to access this.

The practice provided equality and diversity training to staff. The staff we spoke with were very aware of the importance of equality and diversity. We saw staff had regular meetings and felt supported in their role. We saw a range of different staff meetings for individual groups. Examples of these were reception and nurses meeting. This ensured staff had the opportunity to discuss work issues that concerned their individual role and receive regular practice business updates.

The main practice building was situated next to the local community hospital in a two storey building with consulting rooms on the ground floor. Patients with disabilities and patients with pushchairs were able to access all areas of the building. The building was connected to the hospital building. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities and breast feeding.

Access to the service

The practice opened from 8.00 am and appointments were available 8.30am to 5.00pm with the GP Monday to Friday. Commuter appointments for patients who work between 5pm - 5.30pm with a GP. The practice offered extended hours for appointments twice a week 6.30 pm to 7.30pm. Nurse appointments were offered 8.00 am until 6.00 pm. Following the recent patient survey and action planning the nurses now offered a service from 7.20am to 6.00 pm. Appointment with the nurses could be booked six months in advance. The branch surgery held at Lingdale Clinic, on Wednesdays and Fridays between 12.00pm and 2.00 pm. The practice manager told us that although this service was offered it was rarely requested by patients and had not been used since January 2015.

A full appointment system operated for Brotton practice. Appointments can be made with the GP, nurse practitioner or the practice nurses for routine and urgent appointments. Patients with non-urgent requests were able to consult a GP within 48 hours. The practice information stated that patients who wished to see a particular GP may have to wait a few days. Appointments were also available on the day and these could be booked by ringing the practice. Patients could also book appointments with the nurse practitioner who was also a nurse prescriber. The practice also offered telephone appointments and home visits. There was online access to appointments, and repeat prescriptions. We were told that this had proven to be

Good

Are services responsive to people's needs?

(for example, to feedback?)

beneficial for those patients who worked and those who were carers. There were arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for people who needed them and those with long-term conditions. This included appointments with a named GP or nurse. Home visits were made to the local care home.

From the information we reviewed and the patients we spoke with we saw that patients were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice.

We saw that older people and people with long-term conditions could access longer appointments or request a home visit if required. The reception staff were aware they could book longer appointments. Appointments were available outside of school hours for children and young people.

People whose circumstances may make them vulnerable were known to the practice. The practice worked in partnership with other organisations to understand the needs of the most vulnerable and provided flexible longer appointments for those that needed them.

The practice were responsive to people experiencing poor mental health whose life style may be chaotic including hard to reach groups. They were able to provide longer appointments and flexibility when booking appointments.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints which was the practice manager. The practice had complaints leaflets which provided detailed information about the process.

We were told by staff that they would always try and resolve a complaint that was raised with them and if this was not possible, direct them to the practice manager. We saw that information was available to help patients understand the complaints system in the waiting area and online. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at five complaints received in the last 12 months and found these had been satisfactorily handled and dealt with in a timely way. We saw that the practice had an openness and transparency when dealing with the complaints. The complaints had been discussed with staff and the areas of concern raised by patients were systematically addressed in the response from the complaints manager. We saw that clinicians were involved in this process to ensure they were able to explain and address issues raised.

Minutes of practice and other staff meetings showed that complaints were discussed where appropriate with staff and action plans discussed. An example of this was following a patient's complaint of delay in receiving their sick note a plan was put in place to prevent recurrence. The action plans we looked at showed that the practice were proactive in reviewing complaints and ensuring systems were put in place to prevent recurrence.

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 the vision and practice values were part of the practice's future plans. The staff we spoke with were aware of the importance of promoting the practice values and aware of the future plans.

Staff told us that they had regular meetings with their manager where their role in meeting these goals was discussed. The practice manager also told us they operated an open door policy where staff could speak with them at any time. The staff we spoke with confirmed this and told us they were supported and able to discuss concerns and ideas with all members of the management team. Examples of the practice vision and values included improving the patient experience of the service they provided and to improve productivity by reducing waste and inefficiency.

The practice also wanted to improve the work life balance for staff. The practice held regular team and social events to promote good team work. We spoke with nine members of staff and they all knew and understood the vision and values of the practice and what their responsibilities were in relation to these. We saw evidence of good communication and working relationship between staff.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We also saw that hard copies were also available. We looked at these policies and procedures and saw that processes were in place to ensure staff had read the policy. All of the policies and procedures we looked at had been reviewed and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for infection control, for safeguarding and learning disabilities. We spoke with nine members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the QOF to measure its performance. The QOF data for this practice showed it was performing well and in line with national standards. We saw that QOF data was regularly discussed at team meetings and plans were produced to maintain the high standard they were achieving. We also saw that the practice regularly reviewed their performance. Examples of these included reviewing all appointment and prescribing data to understand if they met the needs of the patients.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example we looked at two audits in detail and saw that repeat audit cycles had been completed and actions identified. An example was an audit of contraception prescribing in patients seeking emergency contraception. We saw that following the audit actions were developed, this resulted in following NICE guidance and ensuring all staff adhered to the guidance.

The practice had robust arrangements for identifying, recording and managing risks. The practice had a nominated person who monitored risk. The practice monitored and addressed a wide range of potential issues, such as the environment and infection control. We saw that the risks identified were discussed at the appropriate team meetings and updated in a timely way.

The practice held regular practice meetings and department meetings. We looked at the minutes from the meetings over the last year and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from the minutes of practice meetings that team meetings were held regularly and there were also departmental meetings. Examples of these were clinical, nurses and reception staff. The staff had access to the minutes of the meetings and in-between these times received email notifications of important information. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies. For example recruitment procedures, induction policy, and the staff handbook. Staff we spoke with knew where to find these policies if required.

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

Are services well-led?

Good

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

The practice had gathered feedback from patients through patient surveys, PPG surveys, completed suggestion forms and complaints received. We looked at the results of the 2015 February patient survey and 59% were satisfied with phoning through to practice which was the same as the national average 59%. Following this result they produced an action plan to improve access in the service.

The practice recently developed a patient participation group (PPG). The PPG included representatives from various population groups; including older people and those with long term conditions. The practice met with the PPG to support them to develop their role and future plans.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical and professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place. Staff told us that the practice was very supportive of training and we saw evidence to confirm this.

One of the GP partners had just completed training to become a GP trainer and to support GP registrars. There were currently no GP registrars working at the practice at this stage.

The practice had completed five reviews of significant events. We saw evidence that these were discussed at staff meetings to ensure the practice learned from and improved outcomes for patients. An example of this is was error in the labelling of specimens. The practice put in place systems to ensure further errors would be reduced.