Dr Funmilayo Nixon

Quality Report

Stanhope Parade Health Centre
Gordon Street
South Shields
Tyne and Wear
NE33 4JP
Tel: 0191 2834850
Website: www.westoesurgery.nhs.uk

Date of inspection visit: 9 June 2015
Date of publication: 30/07/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Funmilayo Nixon (also known as Westoe Surgery) on 9 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the following population groups: 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).

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.
- 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.
- The majority of patients said they were able to get an appointment with a GP when they needed one, with urgent appointments available the same day.
- The practice offered pre-bookable early evening appointments one day per week with a GP, practice nurse and healthcare assistant, which improved access for patients who worked full time.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure in place and staff felt supported by management. The practice proactively sought feedback from staff and patients, which they acted on.
- Staff throughout the practice worked well together as a team.

Summary of findings

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

Importantly the provider should:

- Ensure that all clinical audits include at least two cycles. The practice should aim to demonstrate an on-going audit programme where they have made continuous improvements to patient care in a range of clinical areas as a result of clinical audit.
- Continue the work already in progress to review and improve health and safety arrangements, policies and procedures within the practice.

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 their responsibilities to raise concerns, and to report incidents and near misses. We found significant events were recorded, investigated and learned from. Risks to patients were assessed and well managed. The practice had identified the need to review and improve health and safety arrangements, policies and procedures. We saw work was already in progress for this. Disclosure and Barring Service (DBS) checks had been completed for all staff that required them. There were enough staff to keep patients safe.

Good infection control arrangements were in place and the practice was clean and hygienic. Good medicines management arrangements were in place.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were in line with national averages. The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring its effectiveness and had achieved 98% of the points available. This was higher than the local average of 94.9% and the national average of 93.5%. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for staff. Staff worked with multidisciplinary teams which helped to provide effective care and treatment.

Most of the clinical audits we reviewed had been through two audit cycles but some required repeating. The practice should aim to demonstrate an on-going audit programme where they have made continuous improvements to patient care in a range of clinical areas as a result of clinical audit. The practice had achieved slightly lower cervical screening rates (80.2%) compared to the national average (81.9%).

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice in line with or above others for several aspects of care. For example, the National GP Patient

Summary of findings

Survey showed 87% of practice respondents said the last GP they saw or spoke to involved them in decisions about their care and 79% said the last nurse they saw or spoke to involved them in decisions about their care. Both these results were in line with or higher than the local clinical commissioning group (CCG) area and national averages. The CCG averages were 80% and 72%, with the national averages being 75% and 66% respectively. Patients said they were treated with compassion, dignity and respect and they felt involved in decisions about their care and treatment. A total of 47 patients registered with the practice had been initially identified to be at high risk of hospital admission and had agreed care plans in place. 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 privacy and confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They reviewed the needs of their local population and engaged with the clinical commissioning group (CCG) to secure improvements to services where these were identified. Most patients said they found it easy to make an appointment with a GP. Patients were able to book longer appointments on request and pre-bookable appointments with a GP, practice nurse and healthcare assistant were available in the evening one day per week. 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. No formal complaints had been received within the last 12 months; however evidence showed the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. They had clear aims and objectives. Staff knew what their responsibilities were in relation to these. There was a clear leadership structure in place with designated staff in lead roles and staff said they felt supported by management. Team working within the practice between clinical and non-clinical staff was good. The practice had a number of policies and procedures to govern activity and held regular governance meetings. Some of the policies were in the process of being reviewed and updated. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which they acted on. The practice had an active patient participation group (PPG) and was looking to expand this further. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. They offered proactive, personalised care to meet the needs of the older people in its population. For example, all patients over the age of 75 had a named GP and patients at high risk of hospital admission and those in vulnerable circumstances had care plans. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

The practice carried out annual checks for all of their patients over the age of 75. They had 265 patients of this age registered and had consulted with 263 of these (99%) in the last year.

The practice was linked with a local care home and the lead GP completed a ward round at the home once per week. They had received a letter from the care home manager on behalf of the staff, residents and their families thanking them for their work, professionalism and personal approach. The lead GP was accredited with a special interest in Elderly Care.

The practice maintained a palliative care register which included around 1% of their registered patients. They offered immunisations for pneumonia and shingles to older people.

The practice leaflet was printed in a large, easy to read font. This helped to make it easier for those patients who may have sight or reading difficulties to read and understand it.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients were offered a structured review at least annually to check that their health and medication needs were being met. For those people with the most complex needs, the practice worked with relevant health and care professionals to deliver a multidisciplinary package of care. A traffic light system was used to highlight those patients that required more intense input from the clinical team. The list was reviewed on a regular basis and discussed at multidisciplinary meetings.

Summary of findings

The practice held regular chronic disease management clinics in diabetes and for patients with respiratory conditions. The practice had also taken part in a respiratory research day, run by the local district hospital. A medicines optimisation pharmacist supported the practice and kept them updated on medication guidelines.

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. They had initiated regular meetings with the health visitor and midwife. This allowed them to monitor families and children who may be experiencing difficulties and intervene quickly if necessary.

The practice held a weekly baby clinic and arranged baby checks, immunisations and mothers' post-natal checks on the same day. The secretary co-ordinated the clinic and all patient appointments. This helped to reduce the need for mothers, babies and young children to attend on more than one occasion. Immunisation rates were generally higher than the averages for the local CCG. For example, Men C Booster vaccination rates for two year old children were 100% compared to 98.2% across the CCG and Hib/Men C Booster rates for five year old children were 92.6% compared to 90.7% across the CCG.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice was working towards achieving 'You're Welcome' accreditation. 'You're Welcome' is the Department of Health's quality criteria for young people friendly health services.

The practice had achieved slightly lower cervical screening rates (80.2%) compared to the national average (81.9%).

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 and flexible. The practice offered some online services as well as a full range of health promotion and screening which reflects the needs for this age group. GP

appointments could be booked in advance online. The practice had been actively promoting its online services and the number of patients registered for these had increased from 195 to 321 in the last three months; an increase of 65%.

The practice offered extended opening hours one evening per week. Patients could pre-book appointments to see a GP, practice nurse and healthcare assistant at these times. Telephone consultations with clinicians could also be booked on a daily basis. This made it easier for people of working age to get access to the service. NHS health checks were offered to patients between the ages of 40 and 74.

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. Patients with learning disabilities were invited to attend the practice for annual health checks. The practice offered longer appointments for people with a learning disability, if required. The GPs completed regular training in this area to ensure they were offering the best care to those who may not always be in the best position to ask for it themselves.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They supported vulnerable patients and helped them to access various support groups and voluntary 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 normal working hours and out of hours.

There was a women's refuge located close to the practice and the practice offered support to patients from there when they registered with them. This included providing them with assurances that all of their details would be kept confidential.

Staff at the practice had completed 'Stonewall' training and the practice was classed as 'Stonewall friendly'. Stonewall is a lesbian, gay, bisexual and transgender (LGBT) rights charity. The staff we spoke with said it had raised their awareness of the need to treat people equally and to ensure there was no discrimination based on gender or sexual orientation within the practice.

Patients with drug and alcohol dependencies could see support workers at the surgery and the practice also worked closely with the local domestic abuse link worker.

Summary of findings

The practice leaflet was printed in a large, easy to read font. This helped to make it easier for those patients who may have sight or reading difficulties to read and understand it.

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 living with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those living with dementia. They carried out advance care planning for patients living with dementia. The practice had 40 patients on their register as living with dementia and 36 of those patients (90%) had received an annual review of their care in the last 12 months.

The practice had 28 patients on their register as experiencing poor mental health and 21 of those patients (75%) had received an annual health check in the last 12 months.

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

Summary of findings

What people who use the service say

We spoke with eight patients in total; six patients on the day of the inspection and two patients before the inspection who were members of the practice's Patient Participation Group (PPG). They were mostly complimentary about the services they received from the practice. They told us the staff who worked there were helpful and friendly. 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 19 CQC comment cards completed by patients prior to the inspection. The large majority were complimentary about the practice, staff who worked there and the quality of service and care provided. Of the 19 CQC comment cards completed, nine patients made direct reference to the caring and respectful manner of the practice staff. Words used to describe the approach of staff included respectful, lovely, thorough, friendly, caring, helpful, put you at ease, kind and considerate.

The latest National GP Patient Survey published in January 2015 showed that the practice's results were better than other GP practices within the local clinical commissioning group (CCG) area and nationally. Some of the results were:

- The proportion of respondents who were able to get an appointment to see or speak to someone the last time they tried – 91% (CCG average 76%, national average 85%);
- The proportion of respondents who said the last GP they saw or spoke to was good at explaining tests and treatments – 92% (CCG 87%, national 82%);
- The proportion of respondents who said the last GP they saw or spoke to was good at involving them in decisions about their care – 87% (CCG 80%, national 75%);
- The proportion of respondents who said they had confidence and trust in the last GP they saw or spoke to – 98% (CCG 94%, national 92%);
- The proportion of respondents who said the last nurse they saw or spoke to was good at explaining tests and treatments – 83% (CCG 81%, national 77%);
- The proportion of respondents who said the last nurse they saw or spoke to was good at involving them in decisions about their care – 79% (CCG 72%, national 66%);
- The proportion of respondents who said they had confidence and trust in the last nurse they saw or spoke to – 93% (CCG 88%, national 86%).

These results were based on 116 surveys that were returned from a total of 323 sent out; a response rate of 40%.

Areas for improvement

Action the service SHOULD take to improve

The provider should:

- Ensure that all clinical audits include at least two cycles. The practice should aim to demonstrate an on-going audit programme where they have made continuous improvements to patient care in a range of clinical areas as a result of clinical audit.
- Continue the work already in progress to review and improve health and safety arrangements, policies and procedures within the practice.

Dr Funmilayo Nixon

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and an expert by experience. An expert by experience is somebody who has personal experience of using or caring for someone who uses a health, mental health and/or social care service.

Background to Dr Funmilayo Nixon

The practice is based within Stanhope Parade Health Centre in South Shields, Tyne and Wear. The practice serves people living in South Shields. The practice provides services to patients from one location: Stanhope Parade Health Centre, Gordon Street, South Shields, Tyne and Wear, NE33 4JP. We visited this address as part of the inspection.

The practice is located in a purpose built two storey building and provides services to patients at ground floor level. They offer on-site parking including disabled parking, accessible WC's and step-free access. They provide services to just under 2,800 patients of all ages based on a Primary Medical Services (PMS) contract agreement for general practice.

The practice has two GPs in total (both female); the lead GP and one salaried GP. They also employ a long term male locum GP. There is also one practice nurse, one healthcare assistant, a practice manager, a secretary, a senior administrator and four receptionists.

Information taken from Public Health England placed the area in which the practice was located in the fourth more deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The practice's age distribution profile is weighted towards a slightly older population than national averages. There are fewer patients registered with the practice between the ages of 0-19 years than the national averages.

The service for patients requiring urgent medical attention out-of-hours is provided by the 111 service and Northern Doctors Urgent Care Limited.

Why we carried out this inspection

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

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the Care Quality Commission at that time.

Detailed findings

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

• Older people

• People with long-term conditions

• Families, children and young people

• Working age people (including those recently retired and students)

• People whose circumstances may make them vulnerable

• People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice. This did not highlight any areas for follow-up. We also asked other organisations to share what they knew. This included the local clinical commissioning group (CCG).

We carried out an announced inspection on 9 June 2015. We visited the practice's surgery in South Shields. We spoke with eight patients in total and a range of staff from the practice. We spoke with the practice manager, the lead GP, the practice nurse, the healthcare assistant, the secretary, the senior administrator and the reception staff on duty. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 19 CQC comment cards where patients from the practice 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

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how the practice operated. As part of our planning we looked at a range of information available about the practice. This included information from the latest GP Patient Survey results published in January 2015 and the Quality and Outcomes Framework (QOF) results for 2013/14. The latest information available to us indicated there were no areas of concern in relation to patient safety.

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. In addition, none of the patients who completed Care Quality Commission (CQC) comment cards raised any concerns about safety.

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 that everybody had a responsibility to report and record matters of safety.

We saw that records were kept of significant events and incidents. We reviewed a sample of the reports completed by practice staff during the previous two years, and the minutes of meetings where these were discussed. The records we looked at showed the practice had managed these consistently over time and so could demonstrate a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting and recording significant events, incidents and accidents. We saw records were kept of significant events that had occurred, any learning to be taken from them and changes to be made as a result. The summary the practice provided us with showed there had been two 'serious adverse events' recorded during the last 12 months and we looked at the records of these. The number of recorded serious adverse events was quite low; however staff were trained in recognising these and there was no evidence to suggest events were not being recorded appropriately. The practice also reported significant events and incidents to the local clinical commissioning group (CCG), using the local safeguarding incident risk management system (SIRMS). We saw each significant event was recorded, investigated and discussed. Incidents and significant events were brought to the practice's monthly clinical meetings; however they were responded to as soon as they were reported. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff at meetings, by email and on the practice's shared drive computer system. Staff including receptionists, administrators and nursing staff, were aware of the system for raising significant events.

We saw incident forms were available on the practice's shared drive. Once completed these were sent to the practice manager who managed and monitored them. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken.

National patient safety alerts were received into the practice electronically. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. The alerts were reviewed and sent to the appropriate staff for their attention by the practice manager. The practice manager kept an email folder of any alerts received and forwarded on to staff within the practice, however there was no system in place to provide them with assurance these had been read. Staff we spoke with were aware of the system and were able to give examples of recent alerts relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records we reviewed showed that staff had received relevant role specific training on safeguarding. We asked members of 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 regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out-of-hours. We saw contact details were easily accessible to staff throughout the practice.

The practice's lead GP was the designated lead in the safeguarding of vulnerable adults and children. They were

also the GP lead for safeguarding adults across South Tyneside and worked closely with the locality safeguarding team. They had been trained to child safeguarding level three to enable them to fulfil this role. The salaried GP had been trained to this level too. Staff we spoke with were aware of who the lead for the practice was and who to speak with if they had any safeguarding concerns.

The practice's electronic records could be used to highlight vulnerable patients. This included information so staff were aware of any relevant issues when patients attended appointments.

A chaperone policy was in place and a notice was displayed in the patient waiting area to inform them of their right to request one. The practice manager said chaperoning was carried out by clinical and non-clinical staff that had all been trained to fulfil this role. They said the local clinical commissioning group (CCG) were going to arrange some training updates for staff soon. All of the staff that carried out chaperone duties had been checked via the Disclosure and Barring Service (DBS).

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all information about the patient including scanned copies of communications from hospitals.

Medicines Management

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 ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed daily fridge temperature checks had been carried out; this ensured medication was stored at the appropriate temperature.

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. This included the supply of emergency medicines kept by the practice. Expired and unwanted medicines were disposed of in line with waste regulations.

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 and were stored securely at all times. There was a protocol for repeat prescribing which was followed in practice to ensure that patients' repeat prescriptions were still appropriate and necessary.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Some medicines were not put on repeat prescriptions for safety reasons. Examples of these included warfarin, disease-modifying antirheumatic drugs (DMARDs), antidepressants and oral contraceptives.

The practice nurse used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw the practice nurse had received appropriate training to administer vaccines referred to under a PGD.

The practice had clear systems in place to monitor the collection of prescriptions for controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). This had been put into place following an incident where a prescription form could not be traced. The reception staff had come up with an initiative of asking patients to sign brightly coloured slips when they collected their prescription. The slips were reconciled with the controlled drug prescriptions prescribed, which had resulted in all forms being accounted for since the system had been introduced.

The practice was supported by a CCG pharmacist who provided advice and support with prescribing issues.

Cleanliness & Infection Control

We saw the practice was clean, tidy and well maintained. The practice was based in a purpose built health centre shared with two other GP practices and other healthcare professionals. The cleaning of the building was completed by NHS Property Services. 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.

The practice nurse was the designated led for infection control. Staff were able to describe the precautions they

took on a daily basis with regards to infection control; for example on the receipt of specimens from patients. Clinical staff had received training about infection control specific to their role and non-clinical staff had had some in-house training provided.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement infection control measures. For example, personal protective equipment including disposable gloves, aprons and coverings was available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injuries and the disposal and management of clinical waste. All the staff we spoke with knew how to access the practice's infection control policies and procedures.

The clinical rooms we checked contained personal protective equipment such as latex gloves and there were privacy curtains and paper covers for the consultation couches. Arrangements were in place to ensure the curtains were regularly cleaned and replaced. Where sharps bins (used to dispose of needles and blades safely) were contained within consultation rooms, these where appropriately labelled, dated and initialled. The treatment rooms contained hand washing sinks, antibacterial gel and hand towel dispensers to enable clinicians to follow good hand hygiene practice. Hand hygiene techniques signage was displayed throughout the practice. Spillage kits were available to deal with any biological fluid spills.

The practice had processes in place for the management, testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings). We saw NHS Property Services carried out regular checks in line with this to reduce the risk of infection to staff and patients.

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. The practice maintained records showing when the next service was due.

Staffing & Recruitment

The practice had a recruitment policy that set out the standards they followed when recruiting staff. Records we looked at included evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with an appropriate professional body and criminal record checks via the Disclosure and Barring Service (DBS). We looked at the staff file for the member of staff most recently recruited. Their staff file did not contain hard copies of proof of identification. The practice manager explained that documents confirming their identity had been brought to interview and had been seen as part of their Disclosure and Barring Service (DBS) check application process.

The practice manager and all staff had been subject to DBS checks. The GPs had undergone DBS checks as part of their application to be included on the National Medical Performers' List. All performers are required to register for the online DBS update service which enables NHS England to carry out status checks on their certificate.

We asked the practice manager how they assured themselves that GPs and nurses employed continued to be registered to practise with the relevant professional bodies (For GPs this is the General Medical Council (GMC) and for nurses this is the Nursing and Midwifery Council (NMC)). They told us they routinely checked to assure themselves of the continuing registration of staff. We saw records of these checks were maintained. GPs had medical indemnity insurance policies in place and we saw certificates to confirm this.

Staff told us about the arrangements for planning and monitoring the number 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 was enough staff on duty. There were arrangements in place for members of staff to cover each other's annual leave. The practice used a small number of locum GPs to cover for their GPs holidays and other clinical commitments. The practice had a locum induction pack in place.

Good

Are services safe?

Staff told us there were enough staff to maintain the smooth running of the practice and there was always enough staff on duty to ensure patients were kept safe.

Monitoring Safety & 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 regular checks of the building and environment by NHS Property Services, medicines management, staffing, dealing with emergencies and equipment. The practice manager had recently completed some health and safety training and had identified the practice needed to make improvements with regards to health and safety. Health and safety information was not displayed for staff or patients to see and the practice's health and safety policy required some updating. The practice had already arranged for a health and safety appraisal to be completed on 15 June 2015. The practice manager sent us a copy of the initial report after the inspection to confirm this had taken place. The report included an action plan with a number of recommendations made. The practice manager informed us some of these had already been acted on and others were in progress.

We saw a fire risk assessment was in place and the fire alarms within the building were tested every Thursday. A full fire drill had been completed on 4 June 2015. The smoke alarms and emergency lighting was last tested on 16 May 2015.

Staff were able to respond to changing risks to patients, including deteriorating health and medical emergencies. For example, staff who worked in the practice were trained in cardiopulmonary resuscitation (CPR) and basic life support skills. The lead GP said the ability of staff to identify patients whose health was deteriorating was compromised by the layout of the building and they had raised this with the property owners. Staff who worked in the reception area did not have a direct line of sight to their patients in the waiting area. If a patient became unwell, they would be attended to by a clinician in the building and supported by a member of the reception team.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Emergency equipment was available and staff were trained to use it. This included a defibrillator (used to attempt to restart a person's heart in an emergency) and oxygen. NHS Property Services were responsible for the maintenance and servicing of the defibrillator. It was last serviced on 20 May 2015 and was due to be serviced again in November 2015. All the staff we asked knew the location of this equipment.

Emergency medicines were available in a secure area of the practice and all the staff we spoke with knew of their location. Medicines included those for the treatment of cardiac arrest, breathing difficulties and hypoglycaemia. Processes were also in place to check 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 were identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure and loss of access to the building and IT systems. It also included a detailed list of contact details. The plan had been updated in December 2014. The practice manager and lead GP had copies of the plan kept at home. This ensured they had the information they needed to report any problems if they discovered anything that would impact on the operation of the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nursing staff we spoke with could describe the rationale for their treatment approaches. They were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE). We found from our discussions that staff completed thorough assessments of patients' needs and these were reviewed when appropriate. For example, the lead GP showed us how they routinely referred to NICE guidelines when care plans were agreed with patients living with long term conditions or those with terminal illnesses.

The lead GP led on clinical matters, including in specialist clinical areas such as elderly care and dermatology. They were also the clinical lead for long term conditions for the local clinical commissioning group (CCG). They had overall responsibility for ensuring the disease or condition was managed effectively in line with best practice. The practice nurse was responsible, along with the GPs, for ensuring the day-to-day management of a disease or condition was in line with practice protocols and guidance. Clinical staff we spoke with said they would not hesitate to ask for or provide colleagues with advice and support. Staff had access to the necessary equipment and were skilled in its use; for example, blood pressure monitoring equipment.

We spoke with staff about how the practice helped people with long term conditions manage their health. They told us patients were booked in for recall appointments annually, or more frequently if their condition required this. This ensured patients had routine tests, such as blood tests to monitor their condition. The practice was linked to a local care home that was visited weekly by the lead GP. They also completed chronic disease reviews for housebound patients to ensure the treatment they received was not compromised by their inability to attend the practice.

Patients we spoke with said they felt well supported by the GPs and clinical staff with regards to decision making and choices about their treatment. This was reflected in the comments left by patients who completed CQC comment cards.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff from across the practice had roles in the monitoring and improvement of outcomes for patients. These included data input, clinical review scheduling and medicines management. The information staff entered and collected was then used by the practice staff to support the practice to carry out clinical audits and other monitoring activity.

The lead GP was able to show us some clinical audits that had been completed. We looked at three examples of clinical audits, mainly based on medication prescribed, that had been undertaken in the last few years. The audits were generally quite small in terms of the amount of patient data reviewed. For example, an audit on antibiotic prescribing involved nine prescriptions for the first cycle and five prescriptions for the second cycle. In addition, not all of the audits we reviewed had been through two full cycles, so therefore could not demonstrate improvements in outcomes for patients. The audits that had been through two cycles could demonstrate improvements for the small numbers involved. For example, an audit whose aim had been to reduce the prescribing of omega 3 or fish oils for a group of patients showed the number of patients had reduced from five to four during 2014. The practice should aim to demonstrate an on-going audit programme where they have made continuous improvements to patient care in a range of clinical areas as a result of clinical audit.

The practice used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. The Quality and Outcomes Framework is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions (e.g. diabetes) and implementing preventative measures. The results are published annually. This practice was not an outlier for any QOF (or other national) clinical targets. It achieved 98% of the total QOF points available to the practice 2013/2014, which was above the national average of 93.5%. Specific examples to demonstrate this included:

Good

Are services effective?

(for example, treatment is effective)

- Performance for diabetes related indicators was better than the national average (98.1% compared to the national average of 90.1%).
- Performance for asthma related indicators was better than the national average (100% compared to the national average of 97.2%).
- Performance for chronic obstructive pulmonary disease (COPD) related indicators was higher than the national average (100% compared to the national average of 95.2%).

The practice's prescribing rates were similar to national figures. For example, prescribing of antibiotics was in line with national averages. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and asthma and that the latest prescribing guidance was being used.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of these patients and their families. The practice also participated in local prescribing benchmarking run by the CCG. 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 that staff were up to date with attending mandatory courses such as cardiopulmonary resuscitation (CPR) and safeguarding. All GPs were up to date with their yearly continuing professional development requirements and had either 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 the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Nursing staff and the practice manager were appraised by the lead GP and the practice manager appraised the administrative and support staff. We saw records in staff files of appraisals completed within the last 12 months. Staff interviews confirmed that the practice was supportive in providing training and funding for relevant courses.

Nursing staff had defined duties they were expected to carry out and were able to demonstrate they were trained to fulfil these duties. For example, the practice nurse had completed a Chronic Obstructive Pulmonary Disease (COPD) diploma and a course on the management of patients living with diabetes.

The administrative and support staff had clearly defined roles, however they were also able to cover tasks for their colleagues. 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.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage patients with complex health conditions. Blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service, were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers promptly and efficiently. The lead GP saw these documents and results and took responsibility for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team (MDT) meetings to discuss the needs of high risk patients, for example those with end of life care needs and patients with a new diagnosis of cancer. These meetings were attended by a range of healthcare professionals including district nurses, community matrons, palliative care nurses and decisions about care planning were recorded. The practice maintained lists of patients who had learning disabilities, those at high risk of unplanned admissions and patients diagnosed as living with dementia. These and other at risk patients were reviewed and discussed at the MDT meetings.

The practice's GPs and practice nurse attended these meetings and felt this system worked well. They remarked on the usefulness of the meetings as a means of sharing important information. A 'traffic light system' was used to

Good

Are services effective?

(for example, treatment is effective)

indicate those patients that required more intense input from the clinical team. The practice also held regular meetings with midwives and health visitors to discuss the care of children and patients who were expecting children.

The practice was linked with a local care home and the lead GP completed a ward round at the home once per week. They had received a letter from the care home manager on behalf of the staff, residents and their families thanking them for their work, professionalism and personal approach. The lead GP was accredited with a special interest in Elderly Care.

There was a women's refuge located close to the practice and the practice offered support to patients from there when they registered with them. This included providing them with assurances that all of their details would be kept confidential.

Information Sharing

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

Hospital discharge summaries were checked by the GPs, who added or updated any changes to medications for patients. The summaries were then passed to the administrative staff for coding and any other actions that were required. Results of blood tests completed outside the practice for patients prescribed disease-modifying antirheumatic drugs (DMARDs) could be viewed on the Integrated Clinical Environment (ICE) system.

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 on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. They also demonstrated an understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). The lead GP was the GP safeguarding lead across South Tyneside and staff knew to ask them if they were unsure about anything regarding mental capacity. The CCG had provided GPs with training on the Mental Capacity Act.

There was a practice policy for recording consent for specific interventions. For example, verbal consent was taken from patients for routine examinations and verbal and implied consent for the measurement of blood pressure.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. Staff we spoke with gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. The lead GP had attended a shared decision making training event in order to enhance their patient engagement skills.

Health Promotion & Prevention

The practice identified people who needed on-going support and were proactive in offering this. This included carers, those receiving end of life care and those at risk of developing a long term condition. For example, there was a register of all patients diagnosed as living with dementia. Nationally reported QOF data (2013/14) showed that the practice had obtained 100% of the points available to them for providing recommended clinical care and treatment to these patients. The data indicated that 97.2% of patients on the register had a face-to-face annual review in the preceding 12 months. This was 11% above the local CCG average and 13.4% above the England average.

The practice held a weekly baby clinic and arranged baby checks, immunisations and mothers' post-natal checks on the same day. The secretary co-ordinated the clinic and all patient appointments. This helped to reduce the need for mothers, babies and young children to attend on more than one occasion. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance (2013/14) for immunisations was

Good

Are services effective?

(for example, treatment is effective)

generally higher than the averages for the local CCG. For example, Men C Booster vaccination rates for two year old children were 100% compared to 98.2% across the CCG and Hib/Men C Booster rates for five year old children were 92.6% compared to 90.7% across the CCG.

We found patients with long-term conditions were recalled to check on their health and review their medicines for effectiveness. The practice's electronic system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. Staff said this worked well and helped to prevent any patient groups from being overlooked. The practice had also taken part in a respiratory research day, run by the local district hospital

Processes were also in place to ensure the regular screening of patients was completed, for example, cervical screening. Performance in this area for 2013/14 was slightly below the national average at 80.2% (the national average was 81.9%).

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. There was a range of information on display within the patient waiting area. This included a number of health promotion and prevention leaflets, for example on mental health, counselling services and lifestyle advice. The practice's website included links to a range of patient information, including for smoking cessation, alcohol consumption, sexual health and weight management.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with said they were treated with respect and dignity by the practice staff. Comments left by patients on Care Quality Commission (CQC) comment cards reflected this. Of the 19 CQC comment cards completed, nine patients made direct reference to the caring and respectful manner of the practice staff. Words used to describe the approach of staff included respectful, lovely, thorough, friendly, caring, helpful, put you at ease, kind and considerate.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate and caring, while remaining respectful and professional. This was clearly appreciated by the patients who attended the practice. We saw that any questions asked or issues raised by patients were handled appropriately and the staff involved remained polite and courteous at all times.

The reception area was separate from the main patient waiting area, with no direct line of sight between the two. The reception desk to another GP practice who shared the premises was directly adjacent to the practice's own reception desk, with a dividing wall separating the two. We saw staff who worked in the reception area made every effort to maintain patients' privacy and confidentiality. Voices were lowered and personal information was only discussed when absolutely necessary. Phone calls from patients and other healthcare professionals were taken by administrative staff in a separate area where confidentiality could be maintained.

Patients' privacy 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. Staff we spoke with said a spare room was made available for patients to use at the main surgery if they wanted to speak about matters in private. This reduced the risk of personal conversations being overheard.

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 conversations taking place in those rooms could not be overheard.

We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation. Any paper records held were stored securely. Staff were aware of the need to keep records secure and confidential.

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. This included being aware of the diverse ethnic community within South Shields and respecting their individual cultures. Staff at the practice had completed 'Stonewall' training and the practice was classed as 'Stonewall friendly'. Stonewall is a lesbian, gay, bisexual and transgender (LGBT) rights charity. The staff we spoke with said it had raised their awareness of the need to treat people equally and to ensure there was no discrimination based on gender or sexual orientation within the practice.

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey information we reviewed (published in January 2015) showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, and rated the practice well in these areas. For example, the survey showed 87% of practice respondents said the last GP they saw or spoke to involved them in decisions about their care and 79% said the last nurse they saw or spoke to involved them in decisions about their care. Both these results were in line with or higher than the local clinical commissioning group (CCG) area and national averages. The CCG averages were 80% and 72%, with the national averages being 75% and 66% respectively.

In general, the National GP Patient Survey results for the practice were well above the local CCG area and national averages. For example, 97% of respondents said the last GP they saw or spoke to was good at listening to them and 83% of respondents reported the same for the last nurse they saw or spoke to. The CCG averages were 92% and 82%, with the national averages being 87% and 79% respectively. The practice had also scored well in terms of

Good

Are services caring?

patients feeling GPs (92% of respondents) and nurses (83%) explained tests and treatments to them well. This compared to the CCG averages of 87% and 81%, with the national averages being 82% and 77% respectively.

Feedback from patients we spoke with reflected the results from the latest National GP Patient Survey. They 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 said they felt listened to and supported by staff and felt they had sufficient time during consultations to make informed decisions about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and supported these views.

The practice had identified its most at risk and vulnerable patients. They had signed up to the enhanced service for 'Avoiding Unplanned Hospital Admissions' and were completing the work associated with this service. Enhanced Services are services which require an enhanced level of service provision beyond their contractual obligations, for which they receive additional payments. A total of 47 patients had been originally identified as being at high risk of hospital admission. The practice had contacted these patients and with their involvement and agreement, had put agreed plans of care in place. The lead GP described some examples of care plans agreed with a number of at risk patients.

Staff told us that translation services were available for patients who did not have English as a first language. The lead GP said the practice preferred to use these services rather than asking relatives to interpret in order to maintain patients' right to confidentiality.

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 made comments such as the doctors were always there to listen and don't rush you and staff are very supportive too.

Notices in the patient waiting areas signposted patients to a number of support groups and organisations. For example, information was provided for patients who had drug and alcohol problems and a range of information on counselling, mental health and bereavement services was available. The practice website also included information to support its patients. The practice maintained records of patients who were carers and included this information within their clinical records.

Support was provided to patients during times of need, such as in the event of bereavement. Staff we spoke with in the practice recognised the importance of being sensitive to patients' wishes at these times. The lead GP would carry out a home visit or made a telephone call to bereaved relatives at these times to offer support and guidance. The lead GP said they discussed the deaths with the families, with their agreement, to establish if the deceased's preferred place of death was achieved. They said this helped the practice to see if any learning could be taken on board for the benefit of their patients in the future.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients we spoke with and those who filled out Care Quality Commission (CQC) comment cards said they felt the practice was meeting their needs. This included being able to access repeat medicines at short notice when this was required.

The practice engaged regularly with the clinical commissioning group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. For example, staff from the practice met regularly with the CCG commissioning manager to discuss the planning and delivery of services within the practice and more widely locally.

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Staff said patients were encouraged to see the same GP if possible, which enabled good continuity of care. A number of patients had expressed a desire to see the lead GP, regardless of the length of time they had to wait. The practice had responded to this by putting a dedicated receptionist in place to book appointments for the lead GP. Patients could access appointments face-to-face in the practice, receive a telephone consultation with a GP or be visited at home. Longer appointments were available for people who needed them and also on request.

The practice had a palliative care register that included around 1% of the practice's patient list size. The Gold Standards Framework (GSF) on end of life care in primary care states about 1% of the general population will die each year. It suggests the early identification of these patients could lead to better care for them as they approach the end of their lives. The size of the practice's palliative care register reflected this guidance and the lead GP was openly proud of this.

The practice held 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.

The practice had a patient participation group (PPG) and met with them on a quarterly basis. We spoke with two members of the group ahead of the inspection. They said the group was quite small; however they were actively looking to expand its membership beyond the current level of up to eight patients. The group membership included patients from a variety of backgrounds, although they were mostly older patients.

The group members we spoke with said feedback from the group was well received by the practice and a number of changes had been made by them in response to patient feedback. For example, the practice now had a system in place to send patients text message reminders about their appointments as a result of this being suggested by a member of the patient group.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, opening times had been extended to provide pre-bookable early evening appointments with a GP, practice nurse and the healthcare assistant one day per week. This helped to improve access for those patients who worked full time. The day of the week the practice opened late had recently changed from Monday to Wednesday. The practice's website had not been updated to reflect this change to opening times yet, however it had been publicised in the practice newsletter, in the practice leaflet and within the practice itself.

The majority of the practice population were English speaking patients but access to translation services was available if they were needed. The practice maintained registers for patients with caring responsibilities, patients with learning disabilities and patients receiving palliative care. All of these measures helped to ensure that all of their patients had equal opportunities to access the care, treatment and support they needed.

The premises and services had been adapted to meet the needs of people with disabilities. The surgery was located on the ground floor and all services were provided from this level. The main entrance door to the health centre was automated and all of the treatment and consulting rooms could be accessed by those with mobility difficulties. The reception desk counter had been lowered to enable patients who used wheelchairs to speak face to face with the reception staff. We saw that the waiting area were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. This made movement around the practice easier and helped to maintain patients'

Good

Are services responsive to people's needs?

(for example, to feedback?)

independence. The patient toilets could be accessed by patients with disabilities. Dedicated car parking was provided for patients with disabilities in the car park opposite the health centre.

Staff at the practice had completed 'Stonewall' training and the practice was classed as 'Stonewall friendly'. Stonewall is a lesbian, gay, bisexual and transgender (LGBT) rights charity. The staff we spoke with said it had raised their awareness of the need to treat people equally and to ensure there was no discrimination based on gender or sexual orientation within the practice.

The practice accepted any patient who lived within their practice boundary; irrespective of ethnicity, culture, religion or sexual preference.

Access to the service

Most of the patients we spoke with and those who filled out Care Quality Commission (CQC) comment cards said they were satisfied with the appointment systems operated by the practice. Comments included; same day appointments are brilliant, would get me in quickly if appointment needed and easy to make an appointment. One of the 19 patients who filled in CQC comment cards was not as satisfied and commented they sometimes had to wait for an appointment. All of the patients we spoke with said they had been able to see a GP the same day if their need had been urgent.

The latest results from the National GP Patient Survey published in January 2015 were positive in terms of patient feedback regarding appointments. 91% of respondents said they were able to get an appointment to see or speak to someone the last time they tried. This was higher than both the local CCG average of 76% and the national average of 85%. The practice achieved positive results from patients on their experience of making an appointment and the convenience of their last appointment. 81% of respondents said their experience of making an appointment was good (compared to the CCG average 79%) and 93% said their last appointment was convenient (the same as the CCG average). Both of these results were higher than the national averages of 74% and 92% respectively.

The lead GP had completed a survey of their patients as part of their appraisal and revalidation process (every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years). The feedback received indicated patients would prefer the lead GP to spend more time in the practice, rather than meeting their clinical commissioning group (CCG) commitments. As a result of this, the lead GP had reduced their CCG commitments in order to provide more appointments in the practice for their patients. This showed they had responded to feedback received and were attempting to improve access for their patients.

We looked at the practice's appointments system in real-time on the afternoon of the inspection. Routine appointments to see the practice nurse were available within three days and an appointment to see the lead GP was available the following day, as were appointments to see the healthcare assistant. After that, the next routine appointment to see a GP could be booked online within seven days or within two weeks for patients who were not registered for online services. Urgent same-day appointments were released for patients to book each day. The practice offered telephone consultations with GPs too and these were available to be booked on the day.

The practice was open from 8.30am to 6.00pm Monday to Friday. In addition, an early evening surgery with pre-bookable GP, practice nurse and healthcare assistant appointments was held one day per week. The practice's extended opening hours one evening per week were particularly useful to patients with work commitments. This was confirmed by patients we spoke with who normally worked during the week.

Longer appointments were available for patients who needed them. This included longer appointments with a GP or nurse. Home visits were made to those patients who were unable to attend the practice and the lead GP visited a local care home linked to the practice every week.

Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments online. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. The service for patients requiring urgent medical attention out-of-hours was provided by the 111 service and Northern Doctors Urgent Care Limited.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. They had a complaints policy and information on the named responsible person for all complaints received and the timescales by which those who complained should expect a response by was included within the practice leaflet. Information about services and how to complain was available and easy to understand.

We saw the practice had not received any formal complaints in the last 12 months; however we were told about one contact with a patient that had been handled in line with the complaints process. The practice had listened to and spoken with the patient about the matter raised and all parties had agreed on how the matter could be resolved to the satisfaction of all involved.

Staff we spoke with were aware of the practice's policy and knew how to respond in the event of a patient raising a complaint or concern with them directly.

None of the patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice before. In addition, none of the 19 CQC comment cards completed by patients indicated they had raised a complaint with the practice.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The lead GP said the practice's vision was to ensure patients had a good experience when contacting and being seen in the practice, so they felt supported, listened to and viewed as an individual. The practice staff took pride in being a 'family practice'. This was reflected in the practice's statement of purpose. It stated their philosophy was to provide personalised, high quality general practice care to individuals and families alike, and their principle was that patients came first.

We spoke with a variety of practice staff including the practice manager, lead GP, practice nurse, healthcare assistant and some of the practice's administrative and support staff. They all knew and shared the practice's aims and objectives and knew what their responsibilities were in relation to these. Staff regularly spoke of working towards the same aim – making sure their patients were happy with the services provided and got the best treatment available.

Governance Arrangements

The practice had policies and procedures in place to govern activity and these were available to staff within the staff handbook. We looked a sample of these policies and procedures and our discussions with staff demonstrated they had read and understood these. Some of the policies and procedures we looked at had been reviewed recently and were up to date and others were in the process of being reviewed by the practice manager.

The practice used the Quality and Outcomes Framework (QOF) as a means to measure its performance. The QOF data for this practice showed it was generally performing above national standards. We saw that QOF data was discussed at practice meetings and actions were taken to maintain or improve outcomes. For example, reminders were sent to patients if they failed to respond to the request to attend the practice for reviews of their long-term conditions.

The practice had completed a number of clinical audits and reviews or first cycles of clinical audits which it used to monitor quality and systems to identify where action should be taken. The initial reviews (and subsequent audit cycles where these had been completed) had confirmed good practice, however the number of patients identified within the audit samples were relatively small.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and actions to mitigate these risks had been put into place. For example, we saw a fire risk assessment was in place and the fire alarms within the building were tested every Thursday. The practice manager had identified the practice needed to make improvements with regards to health and safety. They had already arranged for a health and safety appraisal to be completed on 15 June 2015 and sent us a copy of the initial report after the inspection to confirm this had taken place. The report included an action plan with a number of recommendations made. The practice manager informed us some of these had already been acted on and others were in progress.

The practice held regular meetings for staff. These included clinical meetings involving the GPs, practice nurse and healthcare assistant twice a month, reception staff meetings and monthly meetings of all staff at times when the surgery closed for 'protected learning time' (PLT). We looked at minutes from some of these meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, the practice manager was the lead for non-clinical matters, the practice nurse had the lead role for infection control and the lead GP was the lead for safeguarding and on clinical matters. We spoke with a range 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 manager was responsible for the application of the provider's human resource policies and procedures. We reviewed a number of policies, for example on the recruitment of staff, chaperoning and infection control, which were in place to support staff. Some of the practice's policies were in the process of being updated. We saw policies were available for all staff to access. Staff we spoke with knew where to find the practice's policies if required.

We found there were good levels of staff satisfaction across the practice. Staff we spoke with were proud of the organisation as a place to work and spoke of the open and honest culture. There were good levels of staff engagement and there was a real sense of team working across all of the staff, both clinical and non-clinical. We saw from minutes

Are services well-led?

Good

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

that whole staff meetings were held. Staff told us they had the opportunity and were happy to raise issues at meetings. Staff also had the opportunity to contribute to staff meeting agendas, and a sheet was placed on the noticeboard in the office reception area for this purpose. Staff we spoke with confirmed any topics for discussion raised through this process were always added to the agenda and covered in staff meetings. They said this process worked well for them and encouraged them to contribute to discussions about how the practice was run.

Practice seeks and acts on feedback from users, public and staff

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

The staff we spoke with, including the practice manager and GPs told us forward planning was discussed. We saw plans were in place to develop and improve the services provided. For example, the practice was due to introduce the electronic prescription service EPS2 soon. The Electronic Prescription Service (EPS) allows the transfer of a prescription from the prescriber to pharmacy by electronic means, rather than the traditional paper form. Staff said they felt listened to and their opinions were valued and contributed to shaping and improving the service.

The practice had a patient participation group (PPG). The PPG had up to eight members from different backgrounds; however plans were in place to promote the group in order to increase the membership and diversity further. The PPG met every quarter and representatives from the practice always attended to support the group. We spoke with some members of the PPG and they felt the practice supported them fully with their work and took on board and reacted to any concerns they raised. The practice had made some changes as a result of feedback from the PPG. This included publicising the number of appointments patients did not attend (DNAs) in an attempt to reduce this and agreeing to promote a local initiative called 'Action Station'. This was a group that taught people, in particular older people, how to use online services. The practice was promoting their own online services to patients and was happy to support this initiative as a way of encouraging their patients to register for online services. The practice had achieved a significant increase in the number of patients signed up for online services; from 195 registered in March 2015 to 321 registered in June 2015; an increase of 65%.

The practice was working towards achieving 'You're Welcome' accreditation. 'You're Welcome' is the Department of Health's quality criteria for young people friendly health services.

Patient feedback from the practice's Friends and Family Test (FFT) results was also routinely reviewed. Since its introduction is December 2014, the practice had received 59 responses in total, with 51 of these being likely or extremely likely to recommend the practice to others. Only two of the six respondents in May 2015 answered positively in this way and the practice manager said they would be monitoring this closely as this contradicted feedback received to date.

The practice had a whistle blowing policy which was available to all staff in their staff handbooks. Staff we spoke with were aware of the policy, how to access it and said they wouldn't hesitate to raise any concerns they had. Staff said significant events were handled within a blame-free culture, which helped to create a culture of dealing positively with circumstances when things went wrong.

Management lead through learning & improvement

Staff said that the practice supported them to maintain their clinical professional development through training and mentoring. We saw that appraisals took place which included a personal development plan. Staff told us that the practice was supportive of training and development opportunities.

The practice had completed reviews of significant events and other incidents and shared these with staff via meetings. These events were discussed, with actions taken to reduce the risk of them happening again.

Are services well-led?

Good

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

The practice manager met with other practice managers in the area and shared learning and experiences from these meetings with colleagues. They were still relatively new to the role and had developed informal support arrangements with their peers and colleagues within the practice. They also said they felt very well supported by the lead GP.

GPs met with colleagues at locality and clinical commissioning group (CCG) meetings. They attended learning events and shared information from these with the other GPs in the practice. The lead GP had a lot of experience of working with the CCG in a number of roles. They were the clinical lead for long term conditions and until recently, had been the clinical director. The leadership skills required for these roles had been used within the practice to good effect.

Information and learning was shared between staff. The practice's schedule of meetings was used to facilitate the flow of information, including meetings of administrative staff, clinical staff and whole staff team meetings. Learning needs were identified through the appraisal process and staff were supported with their development.