North House 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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out this comprehensive inspection on 29 June 2015.

Overall, we rated this practice as requires improvement.

Specifically, we found the practice to require improvement for ensuring safe services, for being responsive and for being well led. The practice was rated as good for providing effective and caring services.

Our key findings were as follows:

- The practice was not able to evidence a good track record for safety. Lessons were not always learned and sufficient improvements were not always made when things went wrong.
- There were not reliable systems, processes and practices to make sure that risks to people were minimised, for example medicines were not managed in accordance with current guidance.
- Patients' needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance.
- Patients' care and treatment outcomes were monitored and compared with other similar services, and these outcomes were comparable to others.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice did not have sufficient GPs. Patients expressed dissatisfaction with the practice because they had difficulty obtaining timely appointments and could not get through to the practice on the telephone.
- Frequent staffing changes, especially amongst GP partners, had destabilised the practice structure, and meant that it was not always easy to identify who clinical leads were for specific areas.
- Although committed to their roles, staff did not feel they were sufficiently kept up to date with changes.

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

Summary of findings

Importantly the provider must:

- Ensure systems are in place for the proper and safe management of medicines, particularly with respect to the monitoring of storage temperature and checking the use-by dates of refrigerated medicines.
- Explore all avenues of staffing and skill mix to ensure the practice is adequately staffed in the medium to long term.

The provider should:

- Ensure that learning from incidents and complaints is fully recorded and cascaded to other staff in order to maximise learning opportunities.
- Ensure staff receive in a timely fashion all required mandatory training updates.
- Ensure that formal governance arrangements are sufficient to fully assess and monitor risks and the quality of the service provision, including clinical and infection control audits.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood the procedures for reporting incidents and felt encouraged to do so. However records showed the practice did not have a robust approach to identify all causes and required actions following an incident. While lessons were learned from incidents, it was not always possible to tell what actions had been taken and what the eventual outcomes were from the practice's records. Lessons were not always communicated widely throughout the practice to allow additional learning opportunities.

The practice did not manage the risks associated with medicine management and infection control effectively.

There were emergency procedures in place to respond appropriately to medical emergencies in the practice. There were insufficient staff, particularly GPs and as a result staff reported they felt pressured.

Are services effective?

Good

The practice is rated as good for providing effective services. Quality data showed most patient outcomes were around average for the locality. Where outcomes were below average the practice engaged with the CCG and specialist staff as necessary to monitor and review this. Guidance from the National Institute for Health and Care Excellence (NICE) was referred to routinely, and patient's needs were assessed and care planned in line with current legislation. This included promotion of good health and assessment of capacity where appropriate. Staff had received training appropriate to their roles, although some elements of mandatory training were overdue. Clinical staff undertook some audits of care and reflected on patient outcomes. The practice worked with other services to improve patient outcomes and shared information appropriately.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients gave us positive feedback where they stated that they were treated with compassion, dignity and respect, and were involved in their treatment and care. In patient surveys, the practice generally scored highly for satisfaction with their care and treatment, with patients saying they were treated with care and concern. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. The practice had an overview of the needs of their local population, and was engaging with the Clinical Commissioning Group (CCG) to secure service improvements. The practice had sufficient facilities and was well equipped to meet patient need. However patient feedback, survey data and an audit of telephone waiting times showed that patients struggled to access the practice by telephone, and while they could generally obtain an urgent appointment on the same day this could mean a long wait on the telephone. Patients also raised concerns around not being able to access their GP of choice. Patients also told us that appointments often ran late.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. It had aims and objectives within the statement of purpose but not all staff were aware of their responsibilities in relation to these. Frequent staffing changes, especially among GPs, had left the practice without a clear leadership structure or long-term strategy. Objectives for improvement were largely short-term and reactive to current staffing difficulties. Lead roles were not always clearly defined, and it was unclear how the allocation of lead roles would be divided in the medium to long term.

Staff perception at a lack of feedback from the management team had at times produced worry and frustration. The practice had a number of policies and procedures to govern activity, which had been reviewed. Systems in place to monitor quality and identify risk were not always kept under review. The practice had an active Patient Participation Group (PPG) and was able to evidence that changes were being made as a result of patient feedback.

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

Requires improvement

The practice is rated as requires improvement for the care of older people. The provider was rated as good for providing effective and caring services and this includes for this population group. However the provider was rated as requires improvement for being safe, responsive and for being well led. The issues which led to these ratings apply to everyone using the practice, including this population group.

The over 75's had a named GP. As part of CCG and Federation initiatives, the practice worked with externally appointed staff, such as advanced nurse practitioners, and community matrons to improve the needs assessment of vulnerable patients such as frail elderly, to reduce admissions, better manage call-outs to care homes, and enable earlier discharge from hospital. The practice held multi-disciplinary meetings to discuss those with chronic conditions or approaching end of life care. Care plans had been produced for those patients deemed at most risk of an unplanned admission to hospital. Information was shared with other services, such as out of hours services and district nurses. Nationally reported data such as the Quality and Outcomes Framework (QOF) showed the practice had outcomes comparable to the average for conditions commonly found in older people.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. The provider was rated as good for providing effective and caring services and this includes for this population group. However the provider was rated as requires improvement for being safe, responsive and for being well led.The issues which led to these ratings apply to everyone using the practice, including this population group.

People with long term conditions were monitored and discussed at multi-disciplinary clinical meetings so the practice was able to respond to their changing needs. Information was made available to out of hours providers for those on end of life care to ensure appropriate care and support was offered. People with conditions such as diabetes and asthma attended regular review appointments to ensure their conditions were monitored, and were involved in making decisions about their care. Attempts were made to contact non-attenders to ensure they had required routine health checks.

Summary of findings

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. The provider was rated as good for providing effective and caring services and this includes for this population group. However the provider was rated as requires improvement for being safe, responsive and for being well led. The issues which led to these ratings apply to everyone using the practice, including this population group.

Systems were in place to identify children who may be at risk. For instance, the practice monitored levels of children's vaccinations and attendances at A&E. Immunisation rates were around the local average for all standard childhood immunisations. Quarterly child protection meetings were held with Health Visitors, School Nurses, Midwives and GPs where concerns were discussed. Full post natal and 8 week baby checks were carried out by GPs, and weekly baby clinics were available at the practice premises. At the time of inspection, the practice was working towards achieving the 'Investing in Children' award. This involved the practice consulting with young people on health matters and how to improve existing services to make them more accessible.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working age people (including those recently retired and students). The provider was rated as good for providing effective and caring services and this includes for this population group. However the provider was rated as requires improvement for being safe, responsive and for being well led. The issues which led to these ratings apply to everyone using the practice, including this population group.

The needs of the working population had been identified, and services adjusted and reviewed accordingly. Routine appointments could be booked in advance, or made online. Repeat prescriptions could be ordered online. Saturday morning appointments were available. The practice had reviewed its telephone system and now kept the lines open for an additional hour over lunchtime. The practice provided NHS health checks for this group including diet and nutrition advice.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people living in vulnerable circumstances. The provider was rated as good for providing effective and caring services and this includes for this

Summary of findings

population group. However the provider was rated as requires improvement for being safe, responsive and for being well led. The issues which led to these ratings apply to everyone using the practice, including this population group.

The practice had a register of those who may be vulnerable, including those with learning disabilities, who were offered annual health checks. Patients or their carers were able to request longer or home appointments if needed. The practice had a register for looked after or otherwise vulnerable children. The computerised patient plans were used to flag up issues where a patient may be vulnerable or require extra support, for instance if they were a carer. Recently a carer's representative from a local support group had been invited to attend a Patient Participation Group meeting.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The provider was rated as good for providing effective and caring services and this includes for this population group. However the provider was rated as requires improvement for being safe, responsive and for being well led. The issues which led to these ratings apply to everyone using the practice, including this population group.

Nationally reviewed data showed the practice carried out additional health checks and monitoring for those experiencing a mental health problem. Dementia diagnosis rates were comparable to the national average. The practice made referrals to other local mental health services as required. Patients with mental health difficulties were able to access a mood management service at the practice. Patients who recently commenced anti-depressants who the GP's felt would benefit from short term, primary care input were referred to the practice's Health Care Assistant (HCA). The HCA supported the patients to access further information, offered help with self-management of their condition and carried out ongoing depression screening.

Summary of findings

What people who use the service say

The latest NHS England GP Patient Survey where 95 patients from the practice responded showed the following:

What this practice does best

94% of respondents say the last GP they saw or spoke to was good at treating them with care and concern

Local (CCG) average: 88% National average: 85%

98% of respondents say the last nurse they saw or spoke to was good at explaining tests and treatments

Local (CCG) average: 93% National average: 90%

90% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care

Local (CCG) average: 86% National average: 81%

What this practice could improve

23% of respondents find it easy to get through to this surgery by phone

Local (CCG) average: 80% National average: 73%

54% of respondents describe their experience of making an appointment as good

Local (CCG) average: 80% National average: 73%

54% of respondents usually wait 15 minutes or less after their appointment time to be seen

Local (CCG) average: 70% National average: 65%

We spoke to five patients during the inspection and collected 14 comment cards which were sent to the practice before the inspection, for patients to complete.

Feedback from these sources indicated patients felt they were treated with respect, and described staff as courteous and helpful. People were generally satisfied with their clinical care. However many patients commented on how busy the practice had become, but said staff remained organised and pleasant under pressure. Patients raised concerns about the availability of appointments, particularly with a preferred GP and difficulties with getting through on the phone. Patients did say they could generally access urgent appointments with any available GP, but that this may mean waiting a long time to get through on the phone, as for accessing routine appointments. Some feedback was received that GP appointments frequently ran over time, however patients were generally satisfied that once they saw the GP they were given sufficient time to explain their problem.

Areas for improvement

Action the service MUST take to improve

- Ensure systems are in place for the proper and safe management of medicines, particularly with respect to the monitoring of storage temperature and checking the use-by dates of refrigerated medicines.
- Explore all avenues of staffing and skill mix to ensure the practice is adequately staffed in the medium to long term.

Action the service SHOULD take to improve

- Ensure that learning from incidents and complaints is fully recorded and cascaded to other staff in order to maximise learning opportunities.
- Ensure staff receive in a timely fashion all required mandatory training updates.
- Ensure that formal governance arrangements are sufficient to fully assess and monitor risks and the quality of the service provision, including clinical and infection control audits.

North House Surgery

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 specialist advisor GP, and a Practice Manager.

Background to North House Surgery

North House surgery provides general medical services (GMS) to approximately 13,600 patients in the town of Crook and surrounding area. The surgery sits within the Durham Dales, Easington and Sedgefield Clinical Commissioning Group (CCG) area.

There are currently six GP partners, and two salaried GPs, a mix of male and female. There is a team of one advanced nurse practitioner, two practice nurse prescribers, one practice nurse and three healthcare assistants. However the practice informed us that by the end of August 2015 three of the eight GPs will have left the practice and there will be two GP partners and three salaried GPs remaining out of the existing. They are supported by a team of management, reception and administrative staff. The practice is a training practice and was supporting two GP registrars.

The practice has higher levels of deprivation compared to the England average. There are higher levels of people aged 55 and above, and more people with a long term health condition, claiming disability living allowance and having caring responsibilities than the England average.

The practice is open from 8.00am until 6:30pm, Monday to Friday. The practice is a member of the Durham Dales Health Federation, comprising 12 practices in the local area.

Why we carried out this inspection

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

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

How we carried out this inspection

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

Detailed findings

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection.

We carried out an announced inspection on 29 June 2015.

We reviewed all areas of the surgery, including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with management staff, GP's, nursing and clinical staff, and administrative and reception staff.

We observed how staff handled patient information received from the out-of-hour's team and patients ringing the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Requires improvement

Are services safe?

Our findings

Safe track record and learning from incidents

Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally where appropriate. Staff said they felt encouraged to report incidents.

Safety was monitored using information from a range of sources such as national patient safety alerts (NPSA), audits and complaints from patients.

GPs told us there was no lead for significant event analysis, and although they were aware of and attended quarterly practice critical incident meetings, some GPs were not aware of recent incidents or overall numbers and trends. The practice did not analyse numbers and types of incidents on a yearly basis, so were not able to fully demonstrate a safe track record over time.

Records showed the practice was not able to identify all causes and required actions following an incident. For instance, in 2014 one incident concerned the wrong label being put on a patient's bloods. The action proposed was for staff to take more care. However, another similar incident occurred after this, where a blood sample was labelled with incorrect patient details. Again the outcome was for staff to be more aware, but there was not a change in systems to assure that such errors would not recur.

The staff told us they had been involved in investigations and informed of the outcome if an incident was directly relevant to them, however there were no whole practice reflective meetings where learning was shared. Staff told us there was some discussion around incidents in staff meetings, however, these were not on a regular basis and incidents were not a standing agenda item due to work load. If they received feedback, it was likely to be via email. Staff therefore felt their overall awareness of incidents and opportunity for learning was limited.

Safety systems and processes including safeguarding

There were arrangements in place to safeguard adults and children from abuse. Staff were generally able to demonstrate they understood their responsibilities in recognising and reporting abuse, and adhered to the practices safeguarding policies and procedures. Although staff had been trained in safeguarding children, some staff had not received training in safeguarding adults. There was therefore a risk that staff would fail to recognise abuse in older people or a vulnerable adult. In discussion staff were sometimes unclear when asked to describe an abuse scenario. The GP safeguarding lead was shortly to leave the practice, with the practice manager stepping in as interim lead. A new clinical lead for safeguarding therefore needed to be appointed.

The practice participated in joint working arrangements and information sharing with other relevant organisations including health visitors and the local authority. This included the identification, review and follow up of vulnerable adults, children, young people and families living in disadvantaged circumstances, including children deemed to be at risk. There was a chaperone policy in place, and GPs noted on patient records when a chaperone had been offered or refused.

Infection Control

We observed the practice to be clean, tidy and well maintained, and staff had received infection control training. Staff followed appropriate infection control and cleaning procedures. However the most recent infection control audit the practice could supply was in 2012, therefore there was a risk that any lapse in procedures would not be promptly identified. Staffing changes meant no-one was actively overseeing the role as infection control lead, and this needed to be reallocated. Clinical waste disposal contracts were in place and spillage kits were available. Waste was managed and disposed of in accordance with current guidance.

Medicines Management

Arrangements for managing medicines in the practice were not sufficient. Several treatment rooms had their own fridge, with each clinical staff member responsible for temperature checking their own. However where a staff member worked part-time or was absent there was no designated person to do this in their absence. Gaps in the recording could not be accounted for. Temperature check recording was therefore incomplete and in the event of a fridge breakdown or power cut staff would be unable to verify how long medicines had been stored out of the correct temperature range. We also found one child's vaccine that had expired in May 2015 and quantities of a carbohydrate supplement with a best before date of April 2015, which showed that stock checking procedures for the fridges were insufficient.

Requires improvement

Are services safe?

Equipment and Facilities

Medical equipment including emergency equipment, electrical equipment, the lift, and fire detection and alarm equipment were all serviced and maintained according to appropriate schedules. The practice had full emergency procedures and evacuation plans in place.

Staffing and recruitment

All the staff we spoke to, particularly GPs and nursing staff said the practice was understaffed. Whilst staff agreed this did not compromise patient safety, staff said they felt very overworked and in some cases overwhelmed, with GPs in particular working long hours to try to keep up with demand. In the previous year the practice had lost in quick succession one salaried GP and three partners. After re-recruiting, at the time of inspection the practice had six partners, but told us they still did not have the required number of GPs to provide enough clinical sessions for their list size of 13,500 patients. Furthermore, the practice stated that by the end of July they would be down to four partners and three salaried GPs, and by the end of August they would be down to two partners and three salaried GPs. The advanced nurse practitioner was also leaving in August.

The practice was actively engaging with the CCG, the Local Medical Committee (LMC) and the Federation in their efforts to find alternative staff. The practice did have two GP interviews scheduled shortly after the inspection and locum cover planned in until the end of August. After the inspection, the practice let us know that three GPs had accepted positions within the practice. Cover was provided for staff on annual leave either by the practice staff doing overtime or through the use of named locum staff. However there was not sufficient detail as to how the practice intended to address their staffing issues in the long term.

The practice assessed required staffing levels against a baseline determined by an appointments audit, and planned forward to identify demand and GP capacity, and where locum cover would be required.

Monitoring safety and responding to risk

Staff identified and responded to changing risks to patients who used the practice by monitoring them for deteriorating health and wellbeing. Patients with a change in their condition were reviewed and referred appropriately.

A monthly premises inspection was carried out but not recorded so we were unable to verify this. An external fire risk assessment carried out in January 2014 flagged up for immediate attention a rear exit fire door which didn't open and combustibles in a server room. Both these issues were still prevalent on checking. The fire door had been fixed in April 2014 but had since re-broken and building checks had not picked this up. A temporary repair was carried out on the day after the inspection.

The practice had recently engaged the service of an external health & safety company, who had assisted with updating the health & safety policy and producing a risk log for the practice. The practice were in the process of cascading these to staff.

Arrangements to deal with emergencies and major incidents

There were emergency procedures and equipment in place to keep people safe. Emergency equipment such as oxygen and defibrillator where checked and serviced regularly. Emergency medicines we checked were in date and stored correctly. However some non-clinical members of staff were overdue for basic life support training.

A business continuity plan included details of emergency scenarios, such as loss of data or utilities, and emergency contact numbers. Potential risks had been taken into account when planning services and anticipating required staff levels, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing. The plan also contained a trigger point for staffing levels, to identify where the practice thought it would be unsafe to operate in the same manner, and therefore additional staff would be required, for instance locum cover.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Assessing patient need and monitoring outcomes

The practice accessed current evidence-based guidance, standards, and best practice such as information from the National Institute for Health and Care Excellence (NICE) and other professional bodies. They used this information to develop how care and treatment was delivered to meet patients' needs. This included during assessment, diagnosis, referral to other services and the management of long-term conditions, including patients requiring end of life care. The practice kept up to date disease registers for patients with long term conditions such as asthma and chronic heart disease. These were used to arrange annual, or as required, health reviews.

The practice routinely collected information about people's care and outcomes. This included data from national incentive schemes (the Quality and Outcome Framework, or QOF, a system which is intended to reward good practice) and clinical audits. QOF results from 2013-14 showed the practice achieved 95.6% of the total number of points available, slightly above the national average of 94.2%.

Staff actively recalled patients for reviews, for example to diabetes and heart disease clinics. Specific examples were supplied for diabetic patients with improved outcomes following additional support from the practice. For example issuing a voice activated blood glucose monitoring machine for patients with specific needs. QOF performance for diabetes related indicators were all around the national averages.

The practice had developed a monitoring scheme for anti-rheumatic medicines & some mental health medicines. When prescribed these drugs, patients were placed into a recall system. Searches were run monthly to ensure patients had received appropriate blood tests and those who had not were invited to attend the surgery. Non-attenders were followed-up.

The practice participated in local benchmarking and initiatives run by the CCG. For instance, engaging with a specialist respiratory nurse aiming to standardise Chronic Obstructive Pulmonary Disease (COPD) care across the region. Results were published monthly, so practices could see where they were improving.

The practice carried out some clinical audits, examples of which included antibiotic prescribing and prescribing for stroke prevention. In an audit of antibiotic prescribing for respiratory tract infections, 70% of patients were initially prescribed the correct choice of antibiotic, this rose to 86% after a period of re-audit.

Effective staffing

GP's had undertaken annual external appraisals and had been revalidated or had a date for revalidation, an assessment to ensure they remain fit to practice. Professional registrations were checked yearly to ensure clinical staff remained fit to practice. Checks were made on qualifications and professional registration as part of the recruitment process. Staff were given an induction and further role specific training when they started.

Continuing Professional Development for nurses was monitored through yearly appraisals. Nursing staff said that while they ensured they kept up to date with mandatory training, they struggled to get the opportunity to attend external peer support or best practice meetings due to the practice being so busy. Some non-clinical staff had last been appraised in 2013, again due to pressures of workload. We saw that some non-clinical staff were overdue for mandatory training such as basic life support and fire safety training.

Nurses did not meet regularly with GPs on an ongoing basis, but did say they could access informal support. GPs attended the clinical meeting once a month, however nurses did not generally attend this. Most staff did agree that they could access support informally when required.

Where poor or variable staff performance was identified the practice had human resources policies and processes to ensure this was effectively managed.

Working with others and Information Sharing

Care was delivered in a coordinated way when different services were involved. As part of CCG and Federation initiatives, the practice worked with externally appointed staff, such as advanced nurse practitioners, and community matrons. This aimed to improve the needs assessment of vulnerable patients such as frail elderly, to reduce admissions, better manage call-outs to care homes, and enable earlier discharge from hospital. QOF data from 2013-14 showed a higher rate of emergency admissions at

Good

Are services effective?

(for example, treatment is effective)

23.39 per 1000 population, higher than the national level of 13.6, although still within accepted limits. The practice was participating in the unplanned admissions service aiming to reduce this figure.

The practice worked with external organisations such as carers groups and the Citizens Advice Bureau (CAB). The CAB attended a weekly session in the surgery to give patients advice. This service had been initiated by the practice.

Regular meetings were held to discuss the needs and treatment strategies of patients with long term conditions, palliative care needs, or those deemed at high risk of unplanned admission. These were attended by other professionals including district nurses and Macmillan Nurses. The practice worked with attached specialist staff, such as respiratory nurses to help enable the practice to meet patient's needs.

There were clear arrangements for referrals and follow-up for patients who had been referred to other services using the NHS online referral service, with clear priority for urgent and cancer referrals. Referrals were completed where possible at the time the patient attended.

All the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practices patient record system and the practice intranet system. This included care and risk assessments, care plans, case notes, test results and discharge letters.

Information was shared with the out of hours services, ambulance crews and hospital staff as appropriate to enable continuity of care.

Consent to care and treatment

We found that staff had received some training and awareness around the Mental Capacity Act 2005 within other subjects such as safeguarding. Staff were generally able to describe key aspects of the legislation and how they would deal with issues around consent, such as involving carers or parents. Further information was available for staff on the practice intranet.

There was a practice policy on consent and mental capacity to support staff and staff knew how to access this. Staff were able to discuss the carer's role and decision making process. Patients were supported to make decisions. Where a patients' mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patients' capacity and, recorded the outcome of the assessment.

Verbal consent, when obtained was documented on the computer as part of a consultation, and staff were able to explain how they would discuss a procedure, detailing risks and benefits.

Health Promotion & Prevention

The practice offered all new patients an assessment of past medical history, care needs and assessment of risk. Advice was given on smoking, alcohol consumption and weight management. Smoking status was recorded and patients were offered advice or referral to a cessation service. Patients over the age of 75 had been allocated a named GP. Nurses said that they tried to use chronic disease management clinics to promote healthy living and ill-health prevention in relation to the person's condition.

Patients aged 40-75 were offered a health check in line with national policy, to help detect early risks and signs of some conditions such as heart disease and diabetes. Rates for childhood immunisations were around the CCG average, for instance 94.8%-97.8% of eligible five year olds had been vaccinated. Weekly child health surveillance clinics were held at the practice. The practice had carried out some promotional work aimed at teenagers, and was working towards gaining the 'investing in children' award. This is where the practice would consult with young people on health matters and how to improve existing services to make them more accessible.

The practice's performance for cervical smear uptake was slightly above the England average at 83.7%. There was a policy to follow up patients who did not attend for cervical smears and the practice audited rates for patients who did not attend. Clinical staff said they opportunistically used patient contact to encourage patients to attend for a smear test when the system flagged up they were overdue.

Patients with mental health difficulties were able to access a mood management service at the practice. Patients who recently commenced anti-depressants who the GP's felt would benefit from short term, primary care input were referred to the practice's Health Care Assistant. This allowed the patients to access further information, help with self-management of their condition and ongoing depression screening.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with five patients during the inspection and collected 14 CQC comment cards which were sent to the practice before the inspection, for patients to complete. Feedback from these sources indicated patients felt they were treated with respect, and described staff as courteous and helpful. Feedback from all these sources was generally very positive, with patients saying they found the clinicians professional and caring. Patients gave specific example of being supported through treatment choices or after bereavement.

The latest national GP Patient Survey where 95 patients responded showed the practice performed above the local CCG averages in areas such as clinicians giving patients enough time, explaining test results, and listening to patients. For instance, 94% of respondents said the last GP they saw or spoke to was good at treating them with care and concern, above the CCG average of 88%

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We observed that reception staff tried to promote privacy in the reception area, and a separate room could be requested if patients wished to have a private conversation.

Although the reception area and website contained some information signposting patients to carers support services, awareness of available services amongst GPs was low. The practice did not proactively seek to identify carers and offer them additional support, although a carer's representative from a local support group had attended a recent Patient Participation Group meeting. The practice did communicate regularly with district nurses and other specialists regarding patients who were on end of life care.

Care planning and involvement in decisions about care and treatment

The templates used on the computer system for people with long term conditions supported staff in helping to involve people in their care. Nursing staff provided examples of where they had discussed care planning and supported patients to make choices about their treatment, for instance the decision of diabetic patients whether to start taking insulin, or use of inhalers for respiratory conditions. Extra time was given during appointments where possible to allow for this.

Patients we spoke to 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. They said they 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. Ninety per cent of 95 respondents to the latest GP patient survey said the last GP they saw or spoke to was good at involving them in decisions about their care, above the CCG average of 86%.

Staff told us there was a translation service available for those whose first language was not English, although staff awareness of these services varied.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to improve outcomes for patients in the area. For example, the Unplanned Admissions scheme covered all ages of patients but specifically the elderly and those with chronic long-term conditions. These patients had same day access to a GP either by telephone or by appointment. Their records were coded to enable surgery staff to identify these patients when they contacted the practice and respond accordingly.

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. These were led by CCG targets for the local area. The diabetes clinics were currently under review to improve patient care and make them more accessible. Certain long-term conditions, such as asthma did not have their own specialist clinics. Patients were seen in normal surgery hours so as to not to restrict them to a specific clinic time. Longer appointments were made available for those with complex needs, for instance patients with diabetes or learning difficulties.

Patients could ask to book with a specific GP to enable continuity of care, however we did receive negative feedback from patients around how easy it was to request and see a specific GP. In the latest GP patient survey, 49% of patients with a preferred GP usually got to see or speak to that GP, this was below the CCG average of 62% and the National average of 60%.

Home visits were available through a triage system and telephone appointments were available where necessary. There was disabled access and parking facilities.

Access to the service

The practice offered online booking for appointments and ordering of repeat prescriptions, although patient uptake had so far been low. The practice was open on a Saturday morning from 8 am to 1 pm, which provided a combination of walk in appointments, patients referred via 111 and some pre-bookable appointments. This service was for all patients within the CCG area, including from other practices.

Appointments were available from 8:00am until 6:00pm Monday to Friday. The practice had recently changed both their phone system and their appointment system in an effort to manage patient demand. The practice stated they were struggling to manage demand due to current staff shortages, particularly GPs, and an increasing patient list size. There was no other practice within the town of Crook for patients to access. The appointment system was made up of pre-bookable appointments up to 2 weeks in advance, book on the day appointments, a daily on-call doctor surgery and a triage clinic.

Patients were dissatisfied and worried regarding access to the service, and gave examples of having to ring in at 8.00am and join a long telephone queue. Concerns were also raised about not being able to get sufficient continuity of care due to the waiting time for a specific GP. Patients said they could generally see any GP for an urgent appointment that day, although this could involve an extensive wait on the telephone. Appointments to see GPs frequently ran late on the day.

Our findings from the inspection mirrored the latest GP patient survey. For instance, only 23% of patients found it easy to get through to the surgery by phone, below the CCG average of 80% and the national average of 73%. 80% were able to get an appointment to see or speak to someone the last time they tried, below the CCG average of 88% and the national average of 85%. 54% usually waited 15 minutes or less after their appointment time to be seen, below the CCG average of 70% and the national average of 65%.

The practice had started to audit monthly telephone waiting times, and for June between 8.00 am and 9.00 am the average waiting time was 14 minutes, although this did drop to 2mins 17secs between 3.00pm and 4.00pm. The practice website acknowledged that patients could have difficulties accessing appointments and apologised for this. Patients were advised of busy times on the website, and to avoid if possible. The practice was actively seeking advice and input from the CCG, the Federation, the PPG and other organisations to help them manage demand. It was too soon to gauge whether changes made to the telephone and appointment systems had caused an appreciable difference to the ease of accessing the service. Other changes, such as offering appointments up to 8 weeks in advance, were planned.

Listening and learning from concerns & complaints

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system in place for handling complaints and concerns. There was a designated responsible person who handled all complaints in the practice. Information on how to complain was contained in reception, and staff were able to signpost people to this.

We looked at a summary of complaints made during the previous 12 months. These included a summary of the complaint, learning points and specific actions to be taken. We could see that the complaints had been investigated, and where necessary the patient had received an apology and a timely response. The practice had previously carried out an annual review to discuss themes and trends, however work pressures meant this had not happened this year.

Patients we spoke with said they would feel comfortable raising a complaint if the need arose. The practice carried out a patient survey in 2014. Results of this survey were available on the practice website. An action plan was drawn up and agreed with the PPG, with actions such as changing the phone and appointment systems. Information on how to make a complaint was available in reception, but not the practice leaflet.

Are services well-led?

Requires improvement

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

Our findings

Vision, Strategy and Culture

The practice's aims and objectives, and a practice ethos were evident in their statement of purpose, and this included treating all patients with dignity, respect and honesty. Some specific aims included to recruit and retain staff, and improve clinical governance. However staff awareness of the practice's objectives varied widely.

Management staff had a plan for the short term future including recruiting additional GPs and a nurse practitioner to try to make sure that care was not compromised. These aims were largely short-term 'fire-fighting' objectives due to the many recent changes in the partnership and unsuccessful retention of new staff. Staff understanding of the vision and strategy was therefore limited, as were their roles in achieving this. It was not clear what the long-term strategy of the practice was, as this was dependent on successful recruitment and retention of staff over the next few months.

Staff we spoke with generally agreed that communication within their own teams was good, and they formed a strong supportive environment. Clinical staff said that although they did not meet formally with the GPs as much as they would like, they could access informal support when required if they asked for it. However staff consistently fed back that they were not kept up to date about management team decisions. Any feedback received was often via e-mail rather than face-to-face. There was concern about the lack of whole practice meetings. As the practice was in a state of flux, the perceived lack of information was causing worry and concern among staff.

Governance Arrangements and Improvement

Staff were sometimes unclear on their individual roles and responsibilities, due to recent staffing changes. For example, the infection control and safeguarding leads were leaving, and it was not clear who was going to fulfil these roles in the long term. It was not clear what the current infection control lead responsibilities entailed, as no audit had been carried out since 2012. There was no clear lead for safe medicines management.

GPs said they felt the leadership structure had been lost due to frequent staffing changes. There were no clinical leads for individual chronic conditions or for Quality and Outcomes Framework (QOF) management. Division and clarity of lead roles between GPs needed to be further developed.

As part of planned changes, a decision had been made for the existing senior partner to step down, and for another GP to become the senior partner. A plan was in place for who would take over as senior partner in the next few months, and staff did feel that some positive changes were starting to take place, such as changes to the appointments and telephone system.

Staff told us they felt able to communicate with doctors or managers if they were asked to do something they felt they were not competent in. The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared computer system. A project had been undertaken to review and update all policies. Policies we looked at such as the whistleblowing policy confidentiality, and consent policies had been recently reviewed.

The practice used the Quality and Outcomes Framework (QOF) to measure performance. The QOF data for this practice showed the previous year results to be slightly above the national average. The practice monitored its results and how to improve, and communicated this to clinical staff. There was some clinical audit carried out, although subjects covered were generally in response to CCG requests rather than following an incident, in response to practice need or from the GP's own reflection of practice. Not all GPs were able to supply completed audits, and some audits reviewed lacked a clearly defined standard against which results were gauged. In addition, there was sometimes no clear evidence of re-audit to check whether actions from previous audits have been successfully implemented and had resulted in improvements to patient care.

The practice had assessed some risks but had not always acted promptly on identified risks, such as those flagged up in the fire risk assessment. Staff told us a monthly health and safety walk-through of the building was carried out where any risks would be identified, however this was not recorded so this was not possible to verify.

Are services well-led?

Requires improvement

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

Staff were able to access monthly 'time out' sessions for learning through the CCG. Nursing staff ensured they remained up to date with professional standards, and this was overseen by the nursing team leader.

We did see some examples of where staff had been able to act on feedback and change practice, for instance changing staffing levels and skill mix to respond to busy periods. However staff sometimes struggled to access learning and sharing opportunities, for example some staff meetings were held at lunchtime, but some staff were paid for lunchtimes and some staff were not, therefore attendance varied.

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

There was an active Patient Participation Group (PPG), which met on average quarterly. Annual patient survey reports and action plans were published on the practice website for the practice population to read. The action plan for 2015 had been presented to the PPG and agreed in discussions, and was largely focused on acting on patient feedback, for instance trying to improve access to the service. Objectives included introduction of a new phone system, which was now complete, and promotion of online services to ease pressure at the reception desk. PPG members had been involved in encouraging patients to order repeat prescriptions online and educating them how to do this.

While staff told us they felt confident giving feedback, they were not always given the means by which to do this and expressed frustration at the lack of whole practice meetings to allow them to discuss concerns and be kept informed of any changes. . The practice had acted on feedback from the CCG and completed a staff and GP survey, although the results of this had yet to be fed back to staff. Although much of the staff team was long-standing and committed to their work, they currently felt disengaged from changes and outcomes taking place within the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not have sufficient clear procedures for the proper and safe management of medicines; in particular for ensuring that refrigerated medicines were kept at the correct temperature, and that out of date medicines were identified and removed.** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 12 (2) (g)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Termination of pregnancies	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not have sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 18 (1)**