South Hylton Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at South Hylton Surgery on 23 April 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. The practice was rated as good for providing services for five of the key population groups. The practice was rated as requires improvement for the population group 'People experiencing poor mental health (including people with dementia).'

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

- The practice had engaged a temporary business services manager until such time as a permanent practice manager could be appointed. The GP partners had given this person a clear remit to deliver an improvement agenda and support the practice to continue developing. Staff told us they felt involved in the process of developing the practice and were well supported by the current practice management team. Weaknesses in the practice's performance had been identified and action had already been taken to address some of these. A development plan was being prepared to support the continuing delivery of good patient care;
- Staff actively sought feedback from patients, and were taking steps to revive their Patient Participation Group (PPG);
- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses;
- Potential risks to patients and staff were being reviewed, and steps had been taken to ensure most were well managed;
- The premises were clean and hygienic, and good infection control arrangements were in place;
- Patients' needs were assessed and care was planned and delivered following best practice guidance. However, the system for recalling patients experiencing mental health problems for their annual healthcare review were not fully effective;
- Patients said they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment;

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- The practice had good facilities and was well equipped to treat patients and meet their needs.

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

- Carry out a Legionella risk assessment;
- Comply with the NHS Protect guidance regarding the security of prescription forms;
- Evaluate and improve the systems in place for recalling patients experiencing mental health problems for their annual healthcare review.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The practice management team took action to ensure lessons were learned from any incidents or concerns that occurred, and shared these with staff to support improvement. Overall, there was evidence of good medicines management. But, NHS Protect guidance regarding the security of prescription forms had not been fully complied with. Good infection control arrangements were in place and the practice was clean and hygienic. Safe staff recruitment practices were followed and there were enough staff to keep patients safe. Staff had completed the training they needed to safely carry out their roles and responsibilities. Patients told us they felt safe using the practice. All risk management strategies were being reviewed by the practice management team to help ensure the safety of patients and staff. However, no steps had been taken to carry out a Legionella risk assessment of the practice's water systems.

Are services effective?

Good

The practice is rated as good for providing effective services.

Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE). The practice had systems in place which helped to improve patient care, including the carrying out of clinical and other types of audits. Staff had access to the information and equipment they needed to deliver effective care and treatment. Arrangements were in place to support clinical staff with their continual professional development and clinical staff had received training appropriate to their roles and responsibilities.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients said they were treated well and were involved in making decisions about their care and treatment. The practice had made arrangements to ensure patients' privacy and dignity was respected. Patients had access to information and advice on health promotion. Staff understood the help patients needed to cope with their care and treatment, and patients received support to manage their own health and wellbeing.

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Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Staff had planned and were providing services that were responsive to the needs of the key population groups registered with the practice. For example, pregnant women were able to access a weekly antenatal clinic provided by a midwife. Nationally reported Quality and Outcomes Framework (QOF) data showed that child development checks were offered at intervals consistent with national guidelines. The data showed the practice had obtained 100% of the total points available to them for providing palliative care to patients. Patients with long-term conditions were able to access an annual healthcare review provided by trained nursing staff.

Patient feedback about appointments was on the whole positive. Of the patients who responded to the National GP Patient Survey of the practice, published in January 2015, 93% described their experience of making an appointment as good. Feedback from the national survey showed the practice had performed better than others within their local CCG area with regards to patient satisfaction with opening hours and being able to get through on the telephone.

The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints procedure and information about how to complain on the practice's website. However, we were unable to make a judgement about how staff implemented the system because we were told the practice had not received any complaints for four years. The temporary business services manager told us the practice's approach to managing complaints was under review and that any improvements that were needed would form part of the practice development plan.

Are services well-led?

Good

The practice is rated as good for being well-led.

The practice had recently faced difficult circumstances which had led the GP partners to take action to appoint a temporary business services manager to provide staff with strong leadership until a new practice manager could be appointed. This person had been given a clear remit to deliver an improvement agenda and support the practice to develop. Staff told us they felt involved in the process of developing the practice and were well supported by the current practice management team. Recent changes had resulted in staff being clearer about their roles and responsibilities. Weaknesses in

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the practice's performance had been identified and action had already been taken to address some of these. A development plan was being prepared to support the continuing delivery of good patient care.

There were a range of policies and procedures covering the day-to-day activities of the practice, although the practice management team acknowledged that some of these needed to be reviewed. Systems were in place to monitor and, where relevant, improve the quality of services provided to patients. The practice had actively sought feedback from patients and used this to improve the services they provided. A recent internal patient survey showed a good level of satisfaction with the care and treatment patients received. An action plan had been devised to help staff address areas where patients felt they could improve.

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 patients.

Nationally reported Quality and Outcomes Framework (QOF) data, for 2013/14, showed most patient outcomes relating to the conditions commonly associated with this population group were either mostly above, or just slightly below, the local Clinical Commissioning Group (CCG) and England averages. For example, QOF data showed the practice had achieved: 98.9% of the total points available to them for providing the recommended care and treatment to patients with heart failure, (this was 0.4 percentage points above the local CCG average and 1.8 points above the England average); 95.2% of the points available to them for providing patients who had had a stroke with the recommended care and treatment, (this was 1.4 percentage points below the local CCG average and 1.1 points below the England average). The practice offered proactive, personalised care to meet the needs of older people. Older patients had been provided with a named GP who was responsible for overseeing their care and treatment. The practice had signed up to the Sunderland CCG scheme 'Time To Think' (TTT) scheme. This involved staff providing extra health and social care support to patients who had been discharged from hospital into a local care home, to help prevent further admissions into hospital. Clinical staff had received the training they needed to provide good outcomes for older patients.

People with long term conditions

Good

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

Nationally reported QOF data, for 2013/14, showed the practice had obtained 88.1% of the total points available to them for providing recommended care and treatment to patients with the long-term conditions covered by the scheme. However, although high, this achievement fell slightly below that of other practices in England and the local CCG, that is 5.3 percentage points below the CCG average and 4.2 points below the England average.

The practice provided a range of services and clinics at the surgery to enable patients to access the care and treatment they needed. For example, the practice nurses carried out home visits for housebound patients to ensure they received healthcare reviews and flu vaccinations. The practice offered patients with long-term conditions an annual check of their health and wellbeing, or more often where this was judged necessary. The mixed clinic system

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offered by the practice provided patients a broad choice of appointment times to help reduce barriers to attendance. Practice nurses had received the training they needed to provide good outcomes for patients with long-term conditions.

Families, children and young people

Good

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

Nationally reported QOF data, for 2013/14, showed the practice had achieved 100% of the total points available to them for providing maternity services and child health surveillance. These were both above the England averages (that is by 0.9 and 1.2 percentage points respectively). The performance of the practice in relation to the provision of maternity services was in line with the local CCG average, and in respect of the provision of child health surveillance, their performance was 3.8 percentage points above the local CCG average.

There were systems for identifying and monitoring children who were considered to be at risk of harm or neglect, and for following up any children who failed to attend for childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. On the basis of the nationally reported data available to the Care Quality Commission (CQC), we saw that, where comparisons allowed, the delivery of the majority of childhood immunisations was either mostly above, or just below, in comparison to the overall percentages for children receiving the same immunisations within the local CCG area. For example, the numbers of children who were given three of the eight childhood immunisations that should be given to children aged five years were above each local CCG average. For four other immunisations, the rates achieved by the practice were just below the local CCG averages.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age patients (including those recently retired and students.)

The needs of this group of patients had been identified and steps taken to provide accessible and flexible care and treatment. The practice was proactive in offering on-line services to patients, such as being able to order repeat prescriptions and book appointments on-line. Extended hours appointments were not available at the practice. However, patients were able to access out-of-hours care and treatment at a local healthcare centre, as the practice was

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participating in a project being led by their local CCG. Health promotion information was available in the waiting area and the practice website provided patients with access to good information about how to improve their health and live healthy lifestyles.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable.

Nationally reported QOF data, for 2013/14, showed the practice had obtained 100% of the points available to them for providing recommended care and treatment to patients with learning disabilities. This achievement was 19.4 percentage points above the local CCG average and 15.9 points above the England average. The practice had a lead clinician for this group of patients and staff had recently completed training to help them understand how to apply best practice standards, when caring for patients with learning disabilities. Staff were aware that some of their patients lived in a nearby care home and had made arrangements to make sure that the reception team offered appropriate support when they attended the practice. Staff worked with members of the multi-disciplinary primary care team to help meet the needs of vulnerable patients. The practice sign-posted vulnerable patients to various support groups and other relevant organisations. Staff were aware of what action to take to report and record concerns about patients' safety, and understood their responsibilities in relation to this.

People experiencing poor mental health (including people with dementia)

Requires improvement

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

Nationally reported QOF data, for 2013/14, showed the practice had achieved 91.2% of the total points available to them for providing recommended care and treatment to patients with dementia. However, although high, this achievement fell slightly below that of other practices in England and the local CCG, that is 3.8 percentage points below the CCG average and 2.2 points below the England average. The practice team had already identified there was scope for improvement and had recently attended a training session to enable them to become 'Dementia Friends'. The practice hoped this would improve recognition and diagnoses rates, as well as providing staff with an awareness of the help and support they could signpost patients to.

Patients with mental health needs, including those not registered with the practice, were able to access counselling and support from

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a visiting mental health counsellor. The practice kept a register of patients with mental health needs which was used to help make sure they received relevant checks and tests. However, nationally reported QOF data, for 2013/14, showed the practice had only obtained 47.7% of the total points available to them for providing patients experiencing poor mental health with the recommended care and treatment. QOF data for 2014/15 showed a similar level of performance. Discussion with practice management staff indicated that the arrangements for informing patients that their healthcare review was due were not effective.

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What people who use the service say

During the inspection we spoke with four patients and reviewed five Care Quality Commission (CQC) comment cards completed by patients. The feedback we received indicated the majority of patients were satisfied with the care and treatment they received. Most patients told us they received a good service which met their needs. Two patients told us they sometimes found it difficult to obtain a same-day appointment and had, on occasions, waited a long time past their appointment time to be seen.

Findings from the National GP Patient Survey of the practice, published in January 2015, indicated most patients had a good level of satisfaction with the care and treatment they received. For example, of the patients who responded to the survey:

- 96% said the last GP they saw, or spoke to, was good at listening to them, (this was above the local CCG and national averages of 88%);
- 96% said the last GP they saw or spoke to was good at giving them enough time, (this was above the local CCG average of 87% and the national average of 86%;
- 97% said the last GP they saw or spoke to was good at treating them with care and concern, (this was above the local CCG average of 84% and the national average of 82%).

These results were based on 112 surveys that were returned from a total of 352 sent out. The response rate was 32%.

Areas for improvement

Action the service SHOULD take to improve

- Carry out a Legionella risk assessment;
- Comply with the NHS Protect guidance regarding the security of prescription forms;
- Evaluate and improve the systems in place for recalling patients experiencing mental health problems for their annual healthcare review.

South Hylton Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a GP and a specialist adviser with a background in practice management. A second CQC inspector was also in attendance.

Background to South Hylton Surgery

South Hylton Surgery is a busy practice providing care and treatment to 3952 patients of all ages, based on a General Medical Services (GMS) contract agreement for general practice. The practice is part of NHS Sunderland Clinical Commissioning Group (CCG) and provides care and treatment to patients living in the South Hylton area of Sunderland.

Sunderland has some of the worst health outcomes in the Country in terms of life expectancy, mortality rates and the prevalence of specific conditions. This has led to a higher level of need for patients with daily living problems and increased risks of admissions to hospital and long-term care. The practice's population includes: more patients aged under 18 years than other practices in the local CCG area; fewer patients aged 65 and over than other practices in the local CCG area. The practice serves an area with lower levels of deprivation affecting children, when compared to other practices in the local CCG. However, the area had higher levels of deprivation affecting older patients aged 65 and over.

The practice provides services from the following address, which we visited during this inspection:

South Hylton Surgery, Union Street, South Hylton, Sunderland, SR4 0LS.

The premises are purpose built and provide fully accessible treatment and consultation rooms for patients with mobility needs. South Hylton Surgery provides a range of services and clinics including, for example, services for patients with asthma, diabetes and coronary heart disease. The practice consists of three GPs (two male and one female), a practice manager, two practice nurses, a trainee healthcare assistant, and a team of administrative and reception staff. Two of the GPs are partners and one is a salaried GP.

When the practice is closed patients can access out-of-hours care via Primecare Urgent Care Services, and the NHS 111 service.

Why we carried out this inspection

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

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

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 (CQC) 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 we held about the practice and asked other organisations to share what they knew about the services it provided. We carried out an announced inspection on 23 April 2015. During this we spoke with a range of staff including: one of the GP partners; a business manager providing short-term support at the practice; a practice nurse, and members of the administrative and reception team. We spoke with four patients and observed how staff communicated with those who visited or telephoned the practice on the day of our inspection. We looked at records the practice maintained in relation to the provision of services. We also reviewed five Care Quality Commission (CQC) comment cards that patients had completed.

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 it operated. Also, the information we reviewed as part of our preparation for this inspection did not identify any concerning indicators relating to safety. The Care Quality Commission (CQC) had not been notified of any safeguarding or whistle-blowing concerns regarding patients who used the practice. The local Clinical Commissioning Group (CCG) did not raise any concerns with us about how this practice operated.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. This information included, for example, significant event reports and national patient safety alerts (NPSA). A procedure was in place which provided staff with guidance about how to respond to and manage medicines alerts. The temporary business services manager told us the GP partners reviewed all medicines alerts received by the practice and advised management staff about any action that needed to be taken. They also told us NPSA alerts were forwarded to the relevant staff so they could, where necessary, take appropriate action.

Staff we spoke to were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. The patients we spoke with raised no concerns about safety at the practice. Records were kept of significant events and incidents. The sample of records we looked at, and evidence obtained from interviews with staff, showed the practice had managed such events consistently and appropriately. This provided evidence of a safe track record for the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. This included using the local safeguarding incident reporting system to report relevant incidents to the local CCG.

Staff we spoke with were aware of the system for raising issues and concerns. We saw evidence which confirmed appropriate learning from significant events had taken place and that the findings were discussed at monthly clinical meetings. The temporary business manager told us one of the practice's priorities for the year ahead was to identify whether improvements could be made to the significant event reporting process. They said any findings from the inspection would be added as a priority to the practice development plan, which was under preparation.

We spoke to staff about how the practice learned from safety incidents, and also looked at some of the records that had been kept. Staff had recorded eight significant events/incidents during the previous 12 months. We saw evidence staff had considered events where they had not got things right, as well as those which demonstrated where practice staff had performed well. One of the significant events we looked at concerned an incident where a member of the team had administered a second vaccination to a child in line with the immunisations schedule. However, the member of staff had failed to identify that the child had not been given the first initial vaccination. We saw the member of staff concerned had raised and discussed the error with one of the GP partners, and had contacted the parent of the child to apologise and explain what had happened. We also saw that, as a consequence of the incident, the member of staff concerned had attended refresher training in administering vaccinations. The practice management team had also discussed what action could be taken to improve how the baby clinics were run. This demonstrated staff had taken the event very seriously and had taken appropriate action to prevent a reoccurrence. However, we found staff did not routinely check whether any actions agreed following a significant event review had been implemented successfully and proved effective. The temporary business services manager had already identified this as an issue and was taking steps to make improvements.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Safeguarding policies and procedures were easily accessible and included information about how to report safeguarding concerns and contact the relevant agencies. One of the GP partners was the safeguarding lead for children and adults. Staff we spoke with said they knew who the safeguarding lead was.

We looked at the arrangements for providing staff with access to appropriate safeguarding training. We found

some staff had completed safeguarding training relevant to their role and responsibilities. Both GP partners, and the salaried GP, had completed child protection training to Level 3. This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns. One of the practice nurses had also completed Level 3 child protection training and the other nurse had completed Level 2. The practice submitted information following the inspection which confirmed all non-clinical staff had completed child protection and adult safeguarding awareness training. All of the staff we spoke to were clear about how they would handle any potential safeguarding concerns.

Patients' records were kept on an electronic system. This system stored all the relevant information about patients, including scanned copies of communications from hospitals. Children and vulnerable adults who were assessed as being at risk were identified via an alert on the clinical IT system. Practice management staff told us that formal separate safeguarding meetings were not held, instead that any concerns would be discussed during practice meetings. They also told us contact would be made with local healthcare professionals, such as health visitors and school nurses, where information needed to be shared. There were arrangements for following up children who failed to attend appointments to help ensure they did not miss important immunisations or other healthcare related checks.

Information about how to access a chaperone was displayed in the reception area and in the consultation and treatment rooms. The practice nurse we spoke to told us nursing staff acted as chaperones and confirmed that they had completed the training they needed to enable them to do this effectively. No concerns were raised by patients about access to chaperones.

Medicines Management

There were suitable arrangements for the GPs to receive advice, support and feedback about their prescribing practice. Information reviewed as part of our preparation for this inspection did not identify any concerns regarding the GPs' prescribing practices. The data we looked at showed the GPs performed as 'similar to expected' when compared to other local practices.

Patients were able to order repeat prescriptions using a variety of ways, such as by calling into the practice, by post or on-line. The practice website advised patients that it was practice policy not to take repeat prescriptions over the telephone, to avoid any errors being made. None of the patients we spoke to on the day of the inspection, or those who completed Care Quality Commission comment cards, raised any concerns about how repeat prescriptions were handled by staff. Staff knew the processes they needed to follow in relation to the authorisation of repeat prescriptions. We observed reception staff dealing effectively with requests for repeat prescriptions. A system was also in place which helped to ensure patients taking prescribed medicines received regular reviews. The GP partner we spoke with told us the doctors carried out six-monthly medicine reviews prompted by alerts on the practice's clinical IT system. The reception staff we spoke to were clear about the process for ensuring patients on repeat prescriptions received a regular medicine review.

There were arrangements for ensuring the security of prescription forms. We confirmed that unused prescription pads were kept in a locked room, and that rooms containing printers with unused prescription forms, were also locked at the end of each day. However, arrangements had not been made to ensure the practice complied fully with the NHS Protect guidance regarding the security of prescription forms. We found staff were not keeping a record of the prescription stationary stock received by the practice or of the serial numbers of the prescription pads given to the GPs. This could make it difficult for staff to confirm that there were no blank prescriptions missing.

Staff had made suitable arrangements to make sure the temperature of medicines requiring cool storage, such as vaccines, was monitored. We confirmed that twice daily temperature checks were carried out and a log kept to confirm these had been completed. Monthly checks of vaccines were also carried out to make sure the 'cold-chain' was being maintained. (A cold-chain is an uninterrupted series of storage and distribution activities which ensure and demonstrate that a medicine is always kept at the right temperature). Effective arrangements were in place for monitoring the expiry dates of emergency medicines held in the GPs' doctor bags.

Cleanliness & Infection Control

The premises were clean and hygienic throughout. Patients told us they had always found the practice to be clean and hygienic. The practice employed their own cleaner and

practice management staff said these arrangements worked well. Notices reminding patients and staff of the importance of hand washing were on display in toilets and other relevant areas.

Infection control policy and procedures were in place and they covered a range of key areas such as, for example, hand hygiene. These provided staff with guidance about the standards of hygiene they were expected to follow. The practice's infection control arrangements had recently been audited by an external organisation and there was an action plan to address the shortfalls identified. Staff had kept a log of the dates on which the shortfalls had been addressed.

The practice nurse we spoke to acted as the practice's infection control lead. They confirmed they had completed advanced training to enable them to carry out this role effectively. They told us they were clear about their roles and responsibilities for monitoring infection control arrangements within the practice. They had recently provided clinical and non-clinical staff with infection control training. This was confirmed by a member of the reception team we spoke with and the records we looked at.

The clinical rooms we visited contained personal protective equipment such as latex gloves, and there were paper covers and privacy screens for the consultation couches. Arrangements had been made for the privacy screens to be regularly changed or cleaned. Spillage kits were available to enable staff to deal safely with any spills of bodily fluids. Sharps bins were available in each treatment room to enable clinicians to safely dispose of needles. The bins had been appropriately labelled, dated and initialled. The treatment rooms also contained hand washing sinks, antiseptic gel and hand towel dispensers to enable clinicians to follow good hand-hygiene practice.

Arrangements had been made to ensure the safe handling of specimens. Reception staff were clear about how they should handle patient specimens to reduce the risk of infection. The practice had a protocol for the management of clinical waste and a contract was in place for its safe disposal. All waste bins were visibly clean and in good working order. Practice management staff told us clinical waste bins were emptied during quiet times at the practice and the bags of waste were stored in the cleaner's cupboard until they were collected. However, the inspection team felt the way that the bags of clinical waste were stored in the cupboard could be improved to minimise the risk of them splitting and spilling their contents. The temporary business services manager told us they would review this system to make sure clinical waste bins were stored safely.

A legionella risk assessment had not been carried out to help ensure the practice's water systems were free of this bacterium. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal).The temporary business services manager told us immediate action would be taken to address this shortfall.

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. The equipment was regularly inspected and serviced. We saw records confirming equipment calibration had last been carried out in September 2014. Staff monitored the safety of the building to make sure patients were not put at risk. We checked the building and found it to be safe and hazard free, apart from a trip hazard outside of the rear fire door exit. The temporary business services manager agreed to address this issue following the inspection. A fire risk assessment had been completed and staff carried out regular safety checks of the fire equipment, such as the fire extinguishers and emergency lighting, to make sure they were in good working order. Recommendations made by the fire service following their last visit to the practice had been actioned. Records indicated a fire drill had been carried out recently. However, there was no recorded evidence to confirm they had been carried out regularly prior to this.

Staffing & Recruitment

The practice had a new and comprehensive recruitment procedure which provided clear guidance concerning the pre–employment checks that should be carried out on staff. All staff had photographic identification in the form of a NHS SMART card. (Staff who have access to patient records are required to undergo rigorous identity checks before they receive their SMART card). Disclosure and Barring Service (DBS) checks had been carried out for all clinical staff. The temporary business services manager told us it was the GP partners' intention to carry out DBS checks for all non-clinical staff as soon as possible regardless of the fact that they did not carry out chaperone duties.

Good

Are services safe?

We checked the General Medical and Nursing and Midwifery Councils records and confirmed that all of the clinical staff were licensed to practice. The temporary business services manager told us all the clinical staff had appropriate medical insurance. We saw evidence of this for all but one member of the clinical team. A member of the practice management team assured us that this member of staff had the relevant insurance. They said the practice had asked to see confirmation of this when the GP was appointed but had not retained a copy to hold on file. We were told a copy of their insurance certificate would be obtained and placed on their recruitment record following the inspection.

A staff appraisal system had been implemented in February 2015 and yearly reviews were scheduled. The business services manager told us this would help to ensure that staff had a formal opportunity to identify any issues and to highlight their personal development and training requirements. There were no formal arrangements for non-clinical staff to have their own regular meetings. However, there was evidence that nursing staff had the opportunity to attend clinical supervision meetings with their peers. The trainee healthcare assistant was undertaking a Level 3 Diploma in Clinical Healthcare Support. The practice management team were able to demonstrate that they were being adequately supervised and mentored by the practice nurse.

The practice was appropriately staffed. The previous practice manager had left the practice unexpectedly in November 2014. Following this the GP partners had made a decision to appoint a temporary business services manager. Due to an unavoidable delay, the practice had been unable to advertise for a replacement practice manager. The temporary business services manager told us succession planning was now seen as a priority.

Effective systems made sure there were enough staff on duty to maintain the smooth running of the practice and to meet patients' needs. Weekly rotas were completed so staff knew who was on duty and in what capacity. There were arrangements for making sure there was always adequate staff cover during, for example, school holidays. It was evident that non-clinical staff were keen to maintain adequate staff cover and effective service delivery following the unexpected departure of the practice manager. In order to do this, some staff were working extra hours.

Staff told us morale had been low towards the end of 2014 but had greatly improved following the changes introduced by the temporary business services manager. The standard of care provided by the practice had recently been recognised when it was nominated and shortlisted for the Sunderland Echo Best of Health Awards under the category of GP Practice of the Year.

Monitoring Safety & Responding to Risk

The practice had systems in place to manage and monitor risks to patients and staff. The temporary business services manager was in the process of assessing potential risks to the health and safety of patients and staff. We saw evidence that some risk assessments had already been completed and others were being developed. For example, a risk assessment screening tool had been used to identify patients at risk of an unplanned admission to hospital. Steps were being taken to complete emergency care plans to help prevent older patients and patients with long-term conditions experience unnecessary admissions into hospital. Information about patients with palliative care needs had been entered onto an electronic system which provided emergency care and out-of-hours clinical staff with access to information about how best to meet their needs. Staff carried out significant event reporting where concerns about patients' safety and well-being had been identified and reviewed. Appropriate arrangements were in place to learn from these and to promote learning within the team.

Arrangements to deal with emergencies and major incidents

There was a business continuity plan to help staff manage the potential impact of emergencies on the day-to-day running of the practice. The temporary business services manager told us they were in the process of reviewing the plan to make sure all the current risks had been identified and assessed, and steps taken to minimise and manage them.

The GPs had either recently completed cardio-pulmonary resuscitation (CPR) training or were shortly due to do so. All of the non-clinical staff and the practice nurses, with the exception of a newly appointed member of the administrative staff, had completed CPR training. However, some of these staff had not refreshed their training within the previous 12 months. Advice from the Resuscitation

Good

Are services safe?

Council (UK) states that all clinical staff should have at least annual updates. The Council also recommends that non-clinical staff should also have their CPR training refreshed annually.

Staff had access to equipment for use in an emergency. This included an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The staff we spoke with knew the location of this equipment and we were able to confirm it was regularly serviced and well maintained.

Emergency medicines were stored securely. They included, for example, medicines for the treatment of a life-threatening allergic reaction and a supply of emergency oxygen. All the emergency medicines were within their expiry date and suitable for use with the exception of one item which had expired in May 2014. We shared this with the practice management team during the feedback session. They told us they felt this was due to human error. The temporary business services manager said they would review the arrangements for checking the expiry dates of emergency medicines to ensure they were effective.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff we spoke with were able to clearly explain why they adopted particular treatment approaches. They were familiar with current best practice guidance and were able to easily access National Institute for Health and Care Excellence (NICE) guidelines. From our discussions with clinical staff we were able to confirm they completed thorough assessments of patients' needs which were in line with NICE guidelines. For example, the clinical audits we looked at provided evidence the GP partners checked their practice against the NICE guidelines to make sure their patients received the best possible care and treatment. The practice nurse told us they had access to a range of electronic assessment tools and care plan templates which they said they used to record details of the assessments they had carried out and what support patients needed. They told us these systems worked well for them.

Patients' needs were reviewed as and when appropriate. Clinical responsibilities were shared between the clinical staff and arrangements were in place for staff to take lead responsibilities for particular areas of practice.

Most of the patients we spoke with said they felt well supported by the GPs and nursing staff and received a good service. This was also reflected in the comments made by patients who completed Care Quality Commission (CQC) comment cards. Interviews with clinical staff showed the culture in the practice was that the care and treatment of patients was based on their needs and staff took account of their age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice had taken steps to manage, monitor and improve outcomes for patients. Staff across the practice had key roles in monitoring and improving outcomes for patients. For example, the GP partners held clinical lead roles in a range of areas including the long-term healthcare conditions covered by the Quality and Outcomes Framework (QOF), and child and adult safeguarding. Other clinical and non-clinical staff had been given responsibilities for carrying out a range of designated roles, such as making sure emergency drugs were in date and the infection control arrangements were satisfactory.

We saw evidence the GP partners had been involved in clinical audit activity to help improve patient outcomes. For example, one of the 'two-cycle' audits we looked at had been carried out to check whether patients with hypertension, who were aged under 60 years of age, were receiving the correct therapy, in line with the relevant NICE guideline. (A two-cycle audit involves an initial audit after which changes are implemented and then a re-audit to demonstrate improvement). We saw that the original findings had been re-audited to establish whether there had been an improvement in the numbers of patients receiving the recommended treatment. The re-audit carried out demonstrated this was the case. Another clinical audit had been undertaken to check whether patients who had had a myocardial infarct (MI) had been prescribed the four medicines recommended in the NICE guidance. The re-audit identified there had been an increase of 14% in the numbers of patients receiving the recommended number of medicines used to treat MI. Other clinical audits had also been undertaken, including a review of cardiology, gynaecology and orthopaedic GP referrals, to ensure these were carried out in line with recommended guidelines. We saw evidence that a range of other audits had been completed to ensure that patients prescribed certain medicines, such as prophylactic Nitrofurantoin (an antibacterial medicine that can be used to treat recurrent urinary tract infection), had undergone recommended checks.

Practice management and clinical staff told us they used the information collected for the QOF, and information about their performance against national screening programmes, to monitor outcomes for patients. Clinical and non-clinical staff were responsible for coding information to enable judgements to be made about compliance with QOF targets. Staff carried out regular searches to check, for example, that patients with long-term conditions had received an invitation to attend their annual review.

Nationally reported data, taken from the QOF for 2013/14, showed the practice had, overall, achieved 88.1% of the total points available to them for providing recommended treatment to patients with the commonly found health conditions covered by the scheme. This was 5.3 percentage points below the local Clinical Commissioning Group (CCG) average and 4.2 points below the England average. However, the clinical GP adviser to the inspection judged this level of performance to be reasonable given the

Good

Are services effective?

(for example, treatment is effective)

population and health demographics of the practice. The information we looked at before we carried out the inspection did not identify this practice as an outlier for any QOF (or other national) clinical targets apart from one exception. This information showed that the percentage of patients with diabetes who had had an albumin:creatinine ratio in the preceding 12 months was below that of other practices in England and the local CCG. (This test is used to identify kidney disease that can occur as a complication of diabetes).

Effective staffing

There were sufficient numbers of reception and administrative staff to carry out the roles and responsibilities that had been allocated to them. Administrative staff were moved between roles to ensure they could each effectively complete all the reception and administrative duties. All of these staff were part-time and were willing to do extra hours as and when needed. The GP partner we spoke with told us the current level of GP cover allowed them to satisfactorily meet the needs of their patients. The practice did not use locum GP cover. Instead, cover was provided in-house with the partners and salaried GP covering each other's leave.

We saw evidence that staff had completed further learning which helped make sure they each had the skills and competencies required to carry out their roles. For example, the practice nurse we spoke with had completed training that enabled them to meet the needs of patients with long-term conditions. For example, they had completed training in diabetes, asthma, heart failure, chronic obstructive pulmonary disease (COPD) and smoking cessation. In addition, they confirmed they had also completed cervical smears and immunisation training updates.

All the GPs were up-to-date with their annual continuing professional development requirements and had either been revalidated or had a date for their 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).

Working with colleagues and other services

Staff worked with other service providers to meet patients' needs and manage complex cases. The practice received communications from local hospitals, the out-of-hours provider and the 111 service, electronically and by post. Staff we spoke with were clear about their responsibilities for reading any letters or information received from other healthcare providers and actioning any issues arising from them. They understood their roles and how the practice's systems worked.

The practice held monthly clinical meetings, which included discussions about vulnerable patients with complex and end of life needs who were at risk of an unplanned emergency admission into hospital. These meetings were attended by the GPs and members of the practice nursing and management teams. In addition, informal meetings were held with local healthcare professionals, such as health visitors and midwifes, to help ensure important information about vulnerable patients was shared among the primary healthcare team. The GP partner we spoke with said these arrangements worked well for them, given the sizes of their practice team and the patient population.

Information Sharing

The practice had systems in place to provide staff with the information they needed to carry out their roles and responsibilities. Staff used an electronic patient record to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Staff used several systems to communicate with other providers. For example, there was an agreed process for accessing information from the local out-of-hours provider, which ensured the practice received information about contact it had with any of its patients. There were arrangements for making sure this information was reviewed and actioned by one of the GPs. The practice shared information about patients with complex care and treatment needs with out-of-hours and emergency care providers. This helped to make sure patient data was shared in a secure and timely manner.

Systems were in place for making referrals using 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.) The GP we spoke

Good

Are services effective?

(for example, treatment is effective)

with said the system worked well for their patients. Information supplied to us by the practice showed that 86% of all practice referrals were made through the Choose and Book system.

Consent to care and treatment

The practice had a consent policy which provided clinical staff with guidance about how to obtain patients' consent to care and treatment, and what to do in the event a patient lacked the capacity to make an informed decision. This policy also highlighted how patients' consent should be recorded in their medical notes, and what type of consent was required for specific interventions.

Clinical staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in complying with it. The GP partner we spoke with demonstrated a clear understanding of consent and capacity issues in relation to children, young people and adults who may lack capacity to make informed decisions about their care and treatment. They were able to clearly explain when consent was necessary and how it would be obtained and recorded. They also demonstrated an understanding of how and when to carry out a Gillick competency assessment. (Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge).

Clinical staff had completed training in the use of the MCA 2005. Staff had received this in a variety of ways including, for example, in-house training by a specialist nurse and external training events.

Health Promotion & Prevention

The processes that had been put in place to ensure the regular screening of patients were for the most part effective. The practice nursing team carried out NHS health checks and new patient checks. These checks help to make sure patients receive the support they need to stay healthy and that any potential health problems are identified early, so that appropriate action can be taken.

Nationally reported QOF data, for 2013/14, showed the practice had obtained 90.1% of the overall points available to them for providing recommended care and treatment to patients who smoked. However, although high, this achievement was slightly below that of other practices in England and the local CCG, that is 4.1 percentage points below the CCG average and 3.6 points below the England average. The QOF data also showed that the medical records of 100% of patients aged over 15, recorded as being smokers, included a record that they had been offered support and treatment during the preceding 24 months. (This level of achievement was 15 percentage points above the local CCG average and 14.8 above the England average). The data confirmed the practice had supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy.

Nationally reported QOF data, for 2013/14, showed the practice had obtained 98.2% of the overall points available to them for providing cervical screening services. However, although high, this achievement fell slightly below that of other practices in the local CCG but above that of other practices in England, that is 1 percentage point below the CCG average and 0.7 points above the England average. The data showed the practice had protocols that were in line with national guidance. This included protocols for the management of cervical screening, and for informing women of the results of these tests. Information supplied to us by the practice showed that 84% of eligible women had attended for cervical screening, following an invitation sent by the practice, during the previous five years. However, practice management staff told us that a recent internal recording failure may have resulted in an under estimate of the number of women who had taken up the offer of a smear test. We were told that this failure had since been addressed. Nationally reported QOF data, for 2013/14, showed the practice had obtained 95.2% of the overall points available to them for providing contraceptive services to women. However, although high, this achievement fell slightly below that of other practices in the local CCG but above that of other practices in England, that is 1.8 percentage points below the CCG average but 0.8 points above the England average.

The temporary business services manager told us work was underway to further improve the practice's QOF performance in all areas, including health promotion, and all systems and processes were being reviewed to deliver this.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice regarding levels of patient satisfaction. The National GP Patient Survey of the practice, published in January 2015, showed good levels of patient satisfaction with the care and treatment offered by the practice. For example, of the patients who responded to the National GP Patient Survey:

- 99% said they had confidence and trust in the last GP they saw or spoke to, (this was above the local Clinical Commissioning Group (CCG) average of 94% and the national average of 93%);
- 96% said the last GP they saw, or spoke to, was good at listening to them, (this was above the local CCG and national averages of 88%);
- 96% said the last GP they saw or spoke to was good at giving them enough time, (this was above the local CCG average of 87% and the national average 86%);
- 97% said the last GP they saw or spoke to was good at treating them with care and concern, (this was above the local CCG average of 84% and the national average of 82%).

We received five Care Quality Commission (CQC) comment cards completed by patients and the feedback was mostly positive. We also spoke with four patients who visited the practice on the day of our inspection. They told us the practice offered a good service and staff were caring and helpful. They confirmed they were treated with dignity and respect, and said staff were also compassionate and understanding.

During the inspection all consultations and treatments were carried out in the privacy of a consulting or treatment room. There were screens in these rooms to enable patients' privacy and dignity to be maintained during examinations and treatments. Consultation and treatment room doors were kept closed when the rooms were in use, so conversations could not be overheard. A member of the reception team told us a private room was available should a patient indicate they wished to speak confidentially to a member of the reception team. A poster in the reception area reminded patients that they should stand back from the desk to help maintain patient privacy. The practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination.

Care planning and involvement in decisions about care and treatment

Data from the National GP Patient Survey of the practice, published in January 2015, showed patients were positive about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. Of those patients who responded to the survey:

- 95% said the last GP they saw or spoke to was good at explaining tests and treatments, (this was above the local CCG average of 85% and the national average of 82%);
- 91% said the GP they visited had been 'good' at involving them in decisions about their care, (this was above the local CCG average of 78% and the national average of 74%).

None of the patients we spoke to on the day of our inspection raised concerns in this area.

Patient/carer support to cope emotionally with care and treatment

We observed patients in the reception area being treated with kindness and compassion by staff. None of the patients we spoke with, or who completed CQC comment cards, raised any concerns about the support they received to cope emotionally with their care and treatment. Notices and leaflets in the waiting room sign-posted patients to a number of relevant support groups and organisations. The practice's IT system alerted clinicians if a patient was also a carer, so this could be taken into consideration when they assessed their need for care and treatment. Staff told us clinicians referred patients struggling with loss and bereavement to appropriate support groups, where this was appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Staff had planned for, and made arrangements to deliver, care and treatment to meet the needs of older patients and those with long-term conditions. They used a risk assessment tool to profile patients according to the risks associated with their conditions. This had enabled them to identify patients at risk of, for example, an unplanned admission into hospital. Staff were in the process of preparing emergency care plans for this group of patients.

Staff kept a register of patients aged 75 years and over, and had written to them explaining which GP would act as their named doctor. Having a named GP helps promote better continuity of care for older patients. Staff told us the practice had signed up to the Sunderland CCG scheme 'Time To Think' (TTT) scheme. The purpose of this scheme is to provide extra health and social care support to patients who have been discharged from hospital into a care home, to help prevent further admissions into hospital. We were told the scheme involved practice staff providing patients living at a local care home with the clinical care they needed to help them return home.

The practice provided a range of additional services at the surgery to enable patients to access the clinical care they needed. For example, clinical staff provided prostate cancer reviews and fitted implants to treat this disease. Patients were also able to access a Warfarin (a blood thinner) clinic where staff checked their blood to make sure the dose they had been prescribed was still appropriate. The practice nurses carried out home visits for housebound patients to make sure they received annual reviews and flu vaccinations. The practice had developed a close working relationship with the adjacent pharmacy. This had enabled pharmacy staff to support patients by arranging prompt deliveries of medicines, and by providing some with weekly packs of medicines, to help keep them safe.

The practice nursing team was mainly responsible for the delivery of chronic disease management. The practice offered patients with long-term conditions, such as asthma and Chronic Obstructive Pulmonary Disease (COPD), an annual check of their health and wellbeing, or more often where this was judged necessary. (COPD is the name for a collection of lung diseases including chronic bronchitis and emphysema.) The mixed clinic system offered by the practice provided patients a broad choice of appointment times, to help reduce barriers to attendance.

Nationally reported Quality and Outcomes Framework (QOF) data, for 2013/14, showed the practice had obtained 88.1% of the total points available to them for providing recommended care and treatment to patients with the long-term conditions covered by the scheme. However, although high, this achievement fell slightly below that of other practices in England and the local CCG, that is 5.3 percentage points below the CCG average and 4.2 points below the England average. There was a system for following up patients who failed to attend for a planned review. One of the patients we spoke with on the day of the inspection told us they had long-term conditions and always got a reminder when they were due to attend for their healthcare review.

The National GP Patient Survey of the practice, published in January 2015, showed the majority of patients were satisfied with how they were treated and the quality of the care and treatment they received. For example, of the patients who responded:

- 82% said the last nurse they saw, or spoke to, was good at listening to them, (this was just below the local CCG average of 86% but above the national average of 79%);
- 85% said the last nurse they saw or spoke to was good at treating them with care and concern, (this was in line with the local CCG average and above the national average of 78%);
- 84% said the last nurse they saw or spoke to was good at explaining tests and treatments, (this was above the local CCG average of 83% and the national average of 77%);
- 75% said the nurse they visited had been 'good' at involving them in decisions about their care, (this was in line with the local CCG average but above the national average of 67%).

Staff kept a register of patients who were in need of palliative care and their IT system alerted clinical staff about those who were receiving this care. Nationally reported Quality Outcomes Framework (QOF) data for 2013/14 showed that multi-disciplinary team (MDT) meetings took place at least every three months, to discuss and review the needs of each patient on this register. The staff we spoke with told us these meetings included

Good

Are services responsive to people's needs?

(for example, to feedback?)

relevant healthcare professionals involved in supporting these patients, such as community nurses and health visitors. The overall QOF score for the practice regarding the provision of palliative care was 5.9 percentage points above the local CCG average and 3.3 points above the England average.

The practice had identified the needs of families, children and young people, and put plans in place to meet them. Pregnant women were able to access an antenatal clinic provided by a midwife, and health visitors offered a baby clinic in the practice's health promotion room. The GPs carried out a review of each baby's development six weeks after their birth to check their health. Nationally reported QOF data, for 2013/14, showed the practice's performance for providing maternity services was in line with the local CCG average and 0.9 percentage points above the England average. The data also showed that antenatal care and screening were offered in line

with current local guidelines, and child development checks were offered at intervals consistent with national guidelines. The practice's performance for carrying out child health surveillance was 3.8 percentage points above the local CCG average and 1.2 points above the England average. Practice staff also provided contraceptive services, including coil fitting and contraceptive injections.

The practice offered a full range of immunisations for children, including the provision of a nurse led baby vaccination clinic, in accordance with national guidance. On the basis of the nationally reported data available to the Care Quality Commission (CQC), we saw that, where comparisons allowed, the delivery of the majority of childhood immunisations was either mostly above, or just below, when compared to the overall percentages for children receiving the same immunisations within the local CCG area. For example, the numbers of children who were given three of the eight childhood immunisations that should be given to children aged five years, were above each local CCG average. For four other immunisations, the rates achieved by the practice were just below the local CCG averages.

Staff had planned its services to meet the needs of the working age population, including those patients who had recently retired. Although the practice did not provide extended hours appointment at the surgery, they were participating in the Sunderland CCG's out-of-hours project at a local treatment centre. The practice website provided patients with information about how to book appointments and order repeat prescriptions on-line.

Staff had taken steps to identify patients with dementia and had made arrangements which helped to meet their needs. The temporary business services manager told us staff carried out dementia reviews in accordance with national recommendations and, where necessary, referred patients to the local specialist memory protection clinic. Nationally reported QOF data, for 2013/14, showed the practice had achieved 91.2% of the total points available to them for providing recommended care and treatment to this group of patients. However, although high, this achievement fell slightly below that of other practices in England and the local CCG, that is 3.8 percentage points below the CCG average but 2.2 points below the England average. The data also showed that only 73.5% of the patients diagnosed with dementia had had their care reviewed in a face-to-face meeting in the preceding 12 months. This was 10.5 percentage points below the local CCG average and 10.3 points below the England average. The practice team had already identified there was scope for improvement. We were told the whole practice team had recently attended a training session to enable them to become 'Dementia Friends'. The temporary business services manager told us the practice hoped this will improve recognition and diagnoses rates, as well as providing staff with an awareness of the help and support they could signpost patients to.

Patients with mental health needs, including those not registered with the practice, were able to access counselling and support from a visiting mental health counsellor. Nationally reported QOF data, for 2013/14, showed the practice had not performed well in providing recommended care and treatment to patients with mental health needs. The data showed the practice had only achieved 47.8% of the total points available to them for treating patients experiencing poor mental health. This was 42.5 percentage points below the local CCG average and 42.6 points below the England average. In particular, the arrangements for informing patients that their healthcare review was due were not effective. The temporary business services manager confirmed the practice had not performed well in this area and agreed that improvements

Good

Are services responsive to people's needs?

(for example, to feedback?)

needed to be made. They told us the provision of healthcare reviews for mental health patients would be made a priority for 2015/16 to ensure they received a better service.

The practice had identified those patients who were cared for and those who were carers. This was flagged on the practice's IT system to alert clinicians, so it could be taken into account when assessing the care and treatment needs of these patients. We saw that information for patients who were also carers was displayed in the reception area.

Staff worked collaboratively with other agencies and regularly shared patient information to ensure good, timely communication of changes in care and treatment. The practice provided the out-of-hours and emergency care services with access to care plan information for patients who had palliative care or complex health needs. This enabled them to provide appropriate care and treatment.

Tackle inequity and promote equality

The practice had made arrangements which demonstrated their commitment to tackling inequity and promoting equality. The majority of patients did not fall into any of the marginalised groups that might be expected to be at risk of experiencing poor access to health care, for example, homeless people and Gypsies and Travellers. However, staff knew there was a care home for people with learning disabilities within their boundary. Practice management staff told us reception staff had been informed that should any of these patients become distressed whilst waiting for their appointment, they should be offered a seat in the health promotion room, until the doctor was ready to see them. The practice had a lead clinician who oversaw the care and treatment provided to patients with learning disabilities. Clinical staff had recently completed training, delivered by a local specialist nurse, to help ensure they understood national guidance about best practice care and treatment relating to this group of patients. The practice had made suitable arrangements to identify and meet the needs of patients with learning disabilities, complex health conditions, and those receiving palliative care. Nationally reported QOF data for 2013/14 showed the practice had achieved all of the points available to them for providing services to patients with learning disabilities. (This was 10.1 percentage points above the local CCG average and 15.9 points above the England average.)

A significant event audit carried out in February 2015 confirmed that clinical staff had a good understanding of the Multi Agency Risk Assessment Conference (MARAC) procedures following the referral of a young person considered to be at risk of violence. (MARAC processes allow statutory and voluntary agencies to give a consistent response to managing the risk posed by perpetrators in cases of domestic abuse).

Reasonable adjustments had been made which helped patients with disabilities and patients whose first language was not English to access the practice. The premises had been purpose built to meet the needs of patients with disabilities. For example, consultation and treatment rooms, and the reception area, were located on the ground floor. Part of the reception desk had been lowered to make reception staff more accessible to patients using wheelchairs. A lift had been installed to help patients access facilities on the first floor. The waiting area was spacious making it easier for patients in wheelchairs to manoeuvre. There was a disabled toilet which had appropriate aids and adaptations. The main doors into the practice were automatic and a ramp provided easy access for wheelchair users. Disabled parking was also available. The practice had a small number of patients whose first language was not English. Staff had access to a telephone translation service and interpreters should they need them.

Access to the service

Appointments were available from 08:30am to 6:00pm five days a week. The practice did not provide extended hours access at the surgery. However, the practice was participating in a CCG led out-of-hours project which provided patients with access to extended hours appointments. Providing extended hours opening makes it easier for working age patients and families to obtain a suitable appointment.

Patients were able to book appointments by telephone, by visiting the practice or on-line. Routine appointments were available which patients could book in advance. The practice website advised patients that staff would aim to offer them an appointment within two working days, or on the same day if their needs were considered to be urgent. The doctors also offered telephone advice should patients prefer this to attending the practice for an appointment. The practice's website and leaflet provided patients with

Good

Are services responsive to people's needs?

(for example, to feedback?)

information about how to access out-of-hours care and treatment. When the practice was closed there was an answerphone message giving the relevant telephone numbers patients should call.

Feedback from the National GP Patient Survey of the practice, published in January 2015, showed the practice had performed better than other practices within their local CCG area with regards to patient satisfaction with opening hours and being able to get through to the practice on the telephone. Of the patients who participated in the survey:

- 84% said they were satisfied with the practice's opening hours, (this was above the local CCG average of 81% and the national average of 76%);
- 95% said they found it 'easy' to get through on the telephone to someone at the practice, (this was above the local CCG average of 79% and the national average of 71%).

Patient feedback about access to appointments was mixed. Most of the feedback we received from patients about access to appointments was positive. Of patients who responded to the National GP Patient survey of the practice, published in January 2015, 93% described their experience of making an appointment as good. However, only 79% said they were able to get an appointment to see or speak with someone when they contacted the practice. (This was just below the local CCG average of 85% and the national average of 86%).

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. However, we were unable to make a judgement about how staff implemented the system because we were told the practice had not received any complaints for four years. The temporary business services manager told us the practice's approach to managing complaints was under review and that any improvements that were needed would form part of the practice development plan which was still being developed.

The practice's complaints policy and procedures were in line with recognised guidance and the contractual obligations for GPs in England. The practice website provided patients with clear information about how to complain. Information about how to complain was also on display within the practice reception area.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had engaged a temporary business services manager until such time as a permanent practice manager could be appointed. The GP partners had given this person a clear remit to deliver an improvement agenda and support the practice to continue developing. Staff told us they felt involved in the process of developing the practice and were well supported by the current practice management team. Weaknesses in the practice's performance had been identified and action had already been taken to address some of these. A development plan was being prepared to support the continuing delivery of good patient care. The inspection team expressed confidence that, although they had only worked at the practice for a short period of time, they already had a good grasp on what needed to be done to deliver the improvements the GP partners wanted.

It was evident during the inspection that the business services manager was actively encouraging and supporting the management team to review how they carried out the day-to-day functions of the practice. The practice website included a clear Mission Statement which expressed the practice's views about the quality of the service they wanted to provide and outlined broadly how they would go about this. Information about the Mission Statement and practice values had also been included in the practice leaflet. A business development plan was being drawn up and all staff were being involved in its preparation. Staff told us the leadership provided by the temporary business services manager had made clear what their roles and responsibilities were and what was expected of them. It was clear staff had begun to carefully consider the future demands likely to be placed on the service, and the potential threats to the successful operation of the business.

Governance Arrangements

The temporary business services manager was in the process of reviewing all the practice's systems and processes to make sure they were effective and safe, and being followed. We saw evidence that the temporary business services manager had already made improvements and strengthened the practice's governance arrangements. For example, the business continuity plan was in the process of being reviewed to ensure it was up-to-date. Staff were in the process of identifying patients at high risk of being admitted into hospital. More regular team meetings had been set up to improve communication and consistency.

Arrangements had been made which supported staff to learn lessons when things went wrong, and to support the identification, promotion and sharing of good practice. For example, we saw evidence confirming that significant events were discussed during practice team meetings. Staff had made arrangements to monitor the practice' clinical performance. Regular checks of the practice disease registers were carried out by designated staff, to help make sure patients received recommended levels of care and treatment. We were told these arrangements worked well. The QOF data, for 2013/14, confirmed the practice participated in an external peer review with other practices in the same Clinical Commissioning Group (CCG), in order to compare data and agree areas for improvement. (Peer review enables practices to access feedback from colleagues about how well they are performing against agreed standards.) Clinical staff carried out audits to help improve patient healthcare outcomes. The practice had a range of policies and procedures in place governing its activities and the services it provided to patients. Staff were able to access these in a variety of ways. All policies and procedures were being reviewed and staff were using a system provided by their local CCG to help them do this.

Leadership, openness and transparency

The recently appointed temporary business services manager had been given a clear mandate to deliver an improvement agenda and support staff to continue to develop good outcomes for patients. Staff told us they felt involved in the process of developing the practice and were well supported by the current management team. Weaknesses in the practice's performance had been identified and action had already been taken to address some of these. A development plan was being prepared to support the continuing delivery of good patient care. Staff told us they welcomed the changes that had been introduced and were positive about them. Staff said things were now more organised and they were clearer about their roles and responsibilities, and what was expected of them. They said they now felt they were an important part

Are services well-led?

Good

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

of the team, and would feel comfortable raising concerns with the management team. Regular practice meetings took place where operational issues and patients' needs were discussed.

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

The practice had made arrangements to seek and act on feedback from patients and staff. For example, patients were invited to complete a Friends and Family Survey (FFS) following a visit to the practice. We saw evidence that arrangements had been put in place to consider and act on feedback from the FFS survey. The practice had had an active patient participation group (PPG) in the past. However, we were told this was now dormant. The temporary business services manager told us they needed to review the current PPG arrangements to identify what steps should be taken to revive the group. The practice had carried out its own survey of patients and an action plan had been developed to address those areas which patients felt improvements could be made. For example, of the patients who had responded to the survey, 65% said they usually wait 15 minutes or less after their appointment time to be seen. According to the survey the local CCG average was 70%. The action plan developed in response to the patient survey stated the management team would carry out a review of GP and nurse waiting times by June 2015 to see what improvements could be made. The management team had gathered feedback from staff through team meetings and the use of staff appraisals, and arrangements had already been made to hold more regular team meetings involving all members of staff.

Management lead through learning & improvement

The practice provided staff with opportunities to continually learn and develop, although we did identify that the arrangements for ensuring that all staff completed their mandatory training could be more effective. A practice nurse told us they had opportunities for continuous learning to enable them to retain their professional registration, and to develop the skills and competencies required for chronic disease management. All of the staff we spoke to said their personal development was encouraged and supported. Staff said they took part in regular 'time-out' sessions, which enabled them to complete the training required for their continuing professional development. Reviews of significant events had also taken place and the outcomes had been shared with staff via meetings. This helped to ensure the practice improved outcomes for patients through continuous learning.