The Saltscar 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 this comprehensive inspection on 9 April 2015.

Overall, we rated this practice as good.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed.
- The practice provided a good standard of care, led by current best practice guidelines.
- Patients were treated with dignity and respect.
- The buildings were clean.
- The practice provided effective care and support to people in vulnerable circumstances, such as those with dementia or learning difficulties.
- The practice had an active Patient Participation Group who worked collaboratively with the practice to improve services and information for patients.

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

In addition the provider should:

- Ensure that all risks to patients who used services were assessed and monitored to ensure patients were kept safe. This should include ensuring that legionella testing takes place and the medicines in the GP's bags are within date and safe to use.
- Ensure that appropriate checks through the Disclosure and Barring Service and training records are kept up to date for all those working in the practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Lessons were learned from incidents and these were communicated throughout the practice. There were sufficient emergency procedures in place to keep people safe. There were sufficient numbers of staff with an appropriate skill mix to keep people safe. Although risks to patients who used services were assessed, the systems and processes to address these risks were not always monitored to ensure patients were kept safe. For example the practice had not undertaken any legionella testing and the medicines in the GP's bags were not reviewed to ensure that they were in date and safe for use. Also the details of recruitment checks and training undertaken for all staff was not comprehensive. Staff understood their roles and responsibilities in raising concerns and reporting incidents.

Are services effective?

Good

The practice is rated as good for providing effective services. Guidance from the National Institute for Health and Care Excellence (NICE) was referred to routinely and people'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 and any further training needs had been identified and appropriate training planned. Clinical staff undertook audits of care and reflected on patient outcomes. The practice worked with other services to improve patient outcomes and shared information appropriately. There was information on health promotion and prevention in the reception area.

Are services caring?

Good

The practice is rated as good for providing caring services. The feedback gathered through the inspection process was positive, with patients stating they were treated with compassion, dignity and respect and were involved in their treatment and care. Information to help patients understand the services available was readily available and easy to understand. Staff respected patient confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had extended opening hours, including a surgery every Saturday morning. The practice monitored the availability of appointments and provided extra appointments at times of

Summary of findings

increased demand. Overall, patients were satisfied with access to both nurse and GP appointments. The practice had a good overview of the needs of their local population and proved additional care and support to vulnerable groups. The practice had good facilities and was well equipped to meet patient need. There was information provided in reception to help people make a complaint.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a visible management team, with a clear leadership structure. Staff felt supported by management. The practice had a vision and values which staff were clear about. There were systems in place to monitor quality and identify risk. The practice had an active Patient Participation Group (PPG) and was able to evidence where changes had been made as a result of PPG and staff 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

Good

The practice is rated as good for the care of older people. The practice held multi-disciplinary meetings to ensure the needs of those with chronic conditions or end of life care were met. Care plans were tailored to meet to individual needs and circumstances. Patients and their carer's were involved in this process. The over 75's had a named GP. Information was shared with other services, such as the out of hours service. Nationally reported data showed the practice had good outcomes for conditions commonly found in older people. It also performed better than the national averages for the percentage of patients over 65 who received a seasonal flu vaccination.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. 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. Clinical staff had obtained qualifications in specific disease areas and the care was based on the latest care and treatment guidelines. 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 nurse clinics, with longer appointment times, to ensure their conditions were appropriately monitored and were involved in making decisions about their care. The practice routinely followed up non-attenders to ensure they had the required routine health checks. The practice referred patients suffering depression, associated with long term conditions, to an in house counselling service.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place to identify children who may be at risk, those on a child protection plan or looked after children. The practice monitored levels of children's vaccinations and immunisation rates were mostly above the national average for childhood immunisations. The practice had developed leaflets specifically aimed at teenagers and young people, this included one on healthy eating. The practice had protected appointment slots to ensure that a child under 12 who was ill would be seen on the same day.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). Routine appointments could be booked up to 12 weeks in advance, or made online. Repeat prescriptions could be ordered online and delivered to a nominated pharmacy. Longer appointments and extended hours opening were available this included appointments on a Saturday morning. An advisor from Job Centre Plus also worked at the practice once a week to provide advice to the long term unemployed who were ill or those experiencing difficulties in the work place.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice had a register of those who may be vulnerable and the practice used the patient records to identify if they required additional support. Patients or their carer's were able to request longer appointments if needed. There was a register for looked after or otherwise vulnerable children and the practice worked with school nurses to follow up if any routine appointments were missed. The practice undertook annual health checks for patients with learning disabilities. It was also working closely with a residential home, for people with learning difficulties and complex health needs, to provide co-ordinated care and support for all of the residents. Staff were aware of their responsibilities in reporting and documenting safeguarding concerns.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Nationally returned data showed the practice performed well in carrying out additional health checks and monitoring for those experiencing a mental health problem. For instance, 97% of patients diagnosed with dementia had their care reviewed in the last 12 months, which was above the national average of 83%. One of the partners specialised in patients with dementia and was the lead in this area. The practice also employed two part time counsellors to provide support and advice to patients experiencing poor mental health.

Summary of findings

What people who use the service say

The NHS England GP Patient Survey from July 2013 - March 2014 showed higher than average levels of satisfaction, for both nurses and GPs treating patients with care and concern. The survey also showed that 80% of patients said it was generally easy to get through to the GP surgery on the phone, this was higher than the national average of 75%.

The practice had also carried out a survey of patients in March 2015. 84% of those who responded said they would be likely to recommend the practice to a friend or relative and 90% said they were fully involved in their care and treatment. However, in this survey ease of accessibility to GPs was only rated as good by 59% of patients.

Feedback on the NHS Choices website included both positive and negative comments, with the majority of the negative comments being about the ability to get appointments. However there were many positive comments about the service and care provided. Overall the practice had a rating of four out of five.

We spoke to two members of the Patient Participation Group (PPG) and four patients during the inspection. This included families with young children, older people and people with long term conditions. The majority of patients had been registered with the practice for a number of years. They were all satisfied with the service provided and said that they were treated with dignity and respect and that staff were caring, professional and approachable. Whilst some patients commented that they may have to wait to get a routine appointment they were always able to get an appointment in an emergency. We also collected 48 CQC comment cards which were sent to the practice before the inspection for patients to complete the comments on this were in line with comments made by patients on the day.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that all risks to patients who used services were assessed and monitored to ensure patients were kept safe. This should include ensuring that legionella testing takes place and the medicines in the GP's bags are within date and safe to use.
- Ensure that appropriate checks through the Disclosure and Barring Service and training records are kept up to date for all those working in the practice.

The Saltscar 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 Practice Manager.

Background to The Saltscar Surgery

The Saltscar Surgery provides General Medical Services to a population of 7,908 patients based at Kirkleatham Road in the centre of Redcar. The practice operates from a purpose built healthcare facility.

There are four GP partners, two male and two female. The practice also has two nurse practitioners, two practice nurses and a healthcare assistant. They are supported by a team of management, reception, administrative and cleaning staff. Out of Hours services are provided via the NHS 111 service.

The practice is in a comparatively deprived area and has a higher than average number of patients with caring responsibilities and patients in receipt of Disability Allowance.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures; family planning; maternity and midwifery services; surgical procedures, and treatment of disease, disorder and injury.

Why we carried out this inspection

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

We carried out the inspection under Section 60 of the Health and Social Care Act 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
- People with long-term conditions
- Families, children and young people

Detailed findings

- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 9 April 2015. During our visit we spoke with a range of staff including the practice manager, GP's, nursing staff, healthcare assistant and administrative and reception staff. We also spoke with two members of the Patient Participation Group and patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service. We reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included reported incidents, national patient safety alerts and complaints, some of which were then investigated as significant events. Prior to inspection the practice gave us details of complaints and significant events from within the last 12 months.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The records showed that staff reported incidents, including their own errors. We reviewed safety records and incident reports and minutes of partners meetings where these were discussed. These showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

The practice had systems in place to circulate safety and medication alerts received into the practice. These were disseminated by email by the practice manager. We found that GPs and nurses were aware of the latest best practice guidelines and incorporated this into their day-to-day practice.

Learning and improvement from safety incidents

We saw where incidents had been discussed and reviewed at partner meetings and the information then shared across the practice as learning points. Staff could access feedback directly via email, staff meetings, or verbally if it concerned them directly. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We could see from a summary of significant events that where necessary the practice had communicated with patients affected to offer a full explanation and apology, and told what actions would be taken as a result. The practice could demonstrate where changes had taken place as a result of an incident, ensuring that staff were aware of what patient information could be shared with other agencies.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Staff had received relevant role specific training on safeguarding and staff we spoke to could describe how they would identify signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. The practice had policies for both the safeguarding of vulnerable adults and safeguarding children.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children and they had had the appropriate training to enable them to fulfil this role. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. Safeguarding concerns were discussed at clinical meetings.

There was a system to highlight vulnerable patients on the practice's electronic records. This included children on a child protection plan, looked after children, adults with safeguarding concerns, patients from travelling communities or with substance misuse issues. The clinical staff confirmed they were able to identify and follow up children, young people and families. Child protection case conferences and reviews were attended by staff where appropriate. We were told that children who persistently fail to attend appointments for childhood immunisations were followed up.

The practice had a chaperone policy and chaperoning was undertaken by the nursing and reception staff. They had received training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Details of the policy and how to ask for a chaperone where available to patients in the reception area.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures. The practice staff followed the policy. Practice staff also checked and recorded the temperatures of the refrigerators on a daily basis.

Good

Are services safe?

In the practice processes were in place to check medicines were within their expiry date and suitable for use. However there was no process in place for checking the contents of the GPs bag and we found some medicines in there to be out of date, however we were told that these medicines were not used. All the other medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. We looked at how vaccines were ordered and saw that they were checked on receipt and stored appropriately in accordance with the manufactures recommendations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. There was a process to regularly review patients' repeat prescriptions to ensure they were still appropriate and necessary. Any changes in medication guidance were communicated to clinical staff. This ensured that staff were aware of any changes and patients received the best treatment for their condition.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness and infection control

We observed all areas of the practice to be clean, tidy and well maintained. Patients we spoke with told us they found the practice to be clean and had no concerns about cleanliness. The practice had infection prevention and control (IPC) and waste disposal policies. There was an identified IPC lead.

We saw evidence that staff had training in IPC to ensure they were up to date in all relevant areas. Aprons, gloves and other personal protective equipment (PPE) were available in all treatment areas as was hand sanitiser and safe hand washing guidance.

Sharps bins were appropriately located, labelled, closed and stored after use. We saw that cleaning schedules for all areas of the practice were in place. Cleaning was carried out by cleaners employed by the practice and cleaning checklists were available. Public toilets were observed to be clean and have supplies of hot water, soap, and paper towels.

Staff said they were given sufficient PPE to allow then to do their jobs safely, and were able to discuss their responsibilities for cleaning and reporting any issues. Staff we spoke with told us that all equipment used for invasive procedures and for minor surgery were disposable. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We saw that other equipment such as blood pressure monitors used in the practice was clean.

The practice did not undertake regular infection control audits and had not undertaken any testing of its water supplies for legionella (a bacterium that can grow in contaminated water and can be potentially fatal). The practice could therefore not provide assurance that it had comprehensive systems and processes in place to reduce the risk of infection to staff and patients

Equipment

We found that equipment such as scales, spirometer, ECG machines (used to detect heart rhythms) and fridges were on external contracts to be checked and calibrated on a timely, regular basis to ensure they were functioning correctly. Regular external checks were carried out on equipment such as fire extinguishers and fire alarms, and portable appliance testing had been carried out. Review dates for all equipment were overseen by the practice manager.

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Staff told us they were trained and knowledgeable in the use of equipment for their daily jobs, and knew how to report faults with equipment.

Staffing and recruitment

Good

Are services safe?

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body. As many of the clinical and nursing staff had been with the practice for many years the practice were not able to provide evidence that the appropriate criminal records checks through the Disclosure and Barring Service had been undertaken when they were recruited and regularly updated. However, the practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff and this included undertaking criminal records checks with the Disclosure and Barring Service.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

The practice also had the services of two counsellors for two sessions a week. The counsellors where provided by an independent private contractor, who had a contract with the local NHS commissioning group. The practice was unable to confirm what checks had been made on these staff, so was not able to confirm if all the appropriate checks had been made.

Staff told us there were enough staff to maintain the smooth running of the practice and keep patients safe.

Monitoring safety and responding to risk

We found that staff recognised changing risks within the service, either for patients using the service or for staff, and were able to respond appropriately. There were procedures in place to assess, manage and monitor risks to patient and staff safety. These included annual and monthly checks and risk assessments of the building, the environment and equipment and medicines management, so patients using the service were not exposed to undue risk.

There were health and safety policies in place covering subjects such as fire safety, manual handling and equipment, and risk assessments for the running of the practice. These were all kept under review to monitor changing risk. Health and safety information was displayed for staff to see and there was an identified health and safety lead.

Patients with a change in their condition or new diagnoses were reviewed appropriately, which allowed clinicians to monitor treatment and adjust according to risk. Information on patients was made available to out of hours providers as required so they would be aware of changing risk.

Arrangements to deal with emergencies and major incidents

Staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. We saw records confirming staff had received basic life support training and Cardio Pulmonary Resuscitation training. Staff could describe the roles of accountability in the practice and what actions they needed to take if an incident or concern arose.

A business continuity plan and emergency procedures were in place which had been reviewed, which included details of scenarios they may be needed in, such as loss of data or utilities. Fire drills were held regularly and fire safety checks were carried out.

Emergency medicines, such as for the treatment of cardiac arrest and anaphylaxis, were available and staff knew their location. Processes were in place to check emergency medicines and these were within their expiry date. A defibrillator and emergency oxygen were available at the practice. Both were checked regularly.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All clinical staff we interviewed were able to describe how they accessed guidelines from the National Institute for Health and Clinical Excellence (NICE) and from local health commissioners. These were received into the practice and disseminated via email by the practice manager.

Treatment was considered in line with evidence based best practice. Clinical meetings with the partners were held regularly to ensure clinicians were kept up to date. All the GP's interviewed were aware of their professional responsibilities to maintain their knowledge and had up to date appraisals. The nurses also met monthly to discuss practice. Guidance was also discussed at practice meetings. Nurses worked alongside GPs within their guidelines for their area of chronic disease management. GPs maintained lead areas of special interest and knowledge including prescribing and dementia.

The practice aimed to ensure that patients had their needs assessed and care planned in accordance with best practice. For instance the practice had recently taken on responsibility for patients in a nearby residential home for people with learning disabilities and were working with both staff at the home and community based nurses to ensure that the care of the patients was assessed and co-ordinated. All over 75s had a named GP.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented. The practice had processes in place to ensure that patients recently discharged from hospital were contacted after discharge to have their care reviewed.

Staff were able to demonstrate how care was planned to meet identified needs using best practice templates and how patients were reviewed at required intervals to ensure their treatment remained effective. The practice kept up to date records of patients with long term conditions such as asthma, diabetes and chronic heart disease which were used to arrange annual, or as required health reviews. They also provided annual reviews to check the health of patients with learning difficulties and mental illness. National data showed the practice was in line with referral rates to secondary care services for a range of conditions. All GP's we spoke with used national standards for referral, for instance two weeks for patients with suspected cancer to be referred and seen.

The practice also used the computer system to identify patients with specific needs, such as those with dementia or who were in need of palliative care and support. National data showed that over 97% of patients diagnosed with dementia had received a face to face review in the last 12 months, this is significantly above the national average of 83%. Patients requiring palliative care were discussed at regular multi-disciplinary care meetings to ensure their needs assessment remained up to date.

We saw no evidence of discrimination when making care or treatment choices, with patients referred on need alone.

Management, monitoring and improving outcomes for people

The practice routinely collected information about people's care and outcomes. It used the Quality and Outcome Framework (QOF) to assess its performance and undertook regular clinical audits. For example in 2014/15 90% of patients with chronic obstructive pulmonary disease (lung disease) had had their condition reviewed.

The practice has a system in place for completing clinical audit cycles. Audits had been undertaken on medications and specific conditions. This included an audit of patients with dementia to review whether they had been assessed for depression. The initial audit findings showed that only 20% of patients had been assessed. Following changes to practice, including scheduling longer appointment times the re-audit showed that 95% of dementia patients had been assessed for depression. This resulted in improving the care for these patients.

Clinical staff checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up when patients needed to attend for a medication review before a repeat prescription was issued and when people needed to attend for routine checks related to their long term condition.

Effective staffing

The practice manager oversaw a training matrix which showed when essential training was due. Training was

Good

Are services effective?

(for example, treatment is effective)

provided through a variety of means including external CCG events, internal training and e-learning. Staff told us the practice was supportive of relevant professional development.

GP's told us they had undertaken annual external appraisals and had been revalidated or had a date for revalidation, an assessment to ensure they remain fit to practice. Continuing Professional Development for nurses was monitored through the appraisals process. Professional qualifications and medical indemnity insurances were checked monthly to ensure clinical staff remained fit to practice.

Staff were appraised annually which generated aims and objectives for staff, with staff able to feed back any problems and what they did well. The recruitment policy of the practice showed that relevant checks were made on qualifications and professional registration as part of the process. On starting, staff commenced an induction comprising health and safety, incident reporting and fire precautions, in addition to further role specific induction training and shadowing of other members of staff.

We saw that mandatory training for clinical staff included safeguarding. Staff also had access to additional training related to their role. Staff said they felt confident in their roles and responsibilities, and were encouraged to ask for help and support, and were able to give examples of when they had asked, for instance, a GP or nurse for additional clinical support if they felt unsure. There were Human Resources (HR) policies and procedures in place to support staff.

The practice was unable to confirm what training had been undertaken by the counsellors who worked at the practice for two sessions a week. We were told that the details of their training would be held by the independent private contractor who employed them.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases, for instance regular multi-disciplinary meetings were held to identify and discuss the needs of those requiring palliative care, or those who would require it. The practice was working towards having links with staff and community nursing staff providing care at a residential home for people with learning difficulties and complex health needs. The practice also provided clinical care to patients in GP beds at Redcar Primary Care Hospital, which enabled them to provide continuity of care from admission to discharge.

Health monitoring of patients with long term conditions was discussed at regular clinical meetings between GPs, to discuss and review treatment strategies and any required actions or changes. District nurses attended for cancer and palliative care meetings.

Information from out of hour's services and NHS 111 contacts was disseminated to GPs to review the next working day so that any required action could be taken. The practice kept 'do not resuscitate' and advance decision registers to reflect patient's wishes, and this information was made available to out of hours providers.

Blood results, discharge letters and information from out of hours providers was generally received electronically and disseminated to doctors. The GP recorded their actions around results or arranged to see the patient as clinically necessary.

Information sharing

Information was shared between staff at the practice by a variety of means. There were mutli-disciplinary team meetings and clinical meetings which were attended by both clinical and administrative staff. Staff received information via meeting minutes, the intranet, or emails.

Referrals were completed by direct letters to the local hospital, and these were completed within appropriate protocols. The practice used the Choose and Book system for referrals where possible. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). There was a shared system with the out of hours provider to enable information to be shared in a timely manner and as appropriate. Urgent information could also be sent or received via fax.

Consent to care and treatment

Clinical staff were aware of the implications of the Mental Capacity Act 2005 and were able to describe key aspects of the legislation and how they implemented it, although not all staff had received training.

Good

Are services effective?

(for example, treatment is effective)

Where patients with a learning disability or other mental health problems were supported to make decisions, this was recorded. If someone had lasting power of attorney concerning a patient this was recorded on the computer and in the patients plan.

Staff were able to explain how they would deal with a situation if someone did not have capacity to give consent, including escalating this for further advice to a senior member of staff where necessary. Verbal consent was documented on the computer as part of a consultation. Written consent forms were used for invasive procedures such as ear syringing or coil fitting, which detailed risks, benefits and potential complications, which allowed patients to make an informed choice.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

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 used chronic disease management clinics to promote healthy living and health prevention in relation to the person's condition. Patients aged 40-74 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. New patients were offered health checks.

In addition to routine immunisations the practice offered flu vaccinations in line with current national guidance. Data showed childhood immunisation rates were above or in line with national figures.

The practice provided a wide range of information on health promotion and prevention to patients in the reception area. This included how to access psychological and talking therapy services, healthy eating for teenagers and support for carers.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke to four patients during the inspection and two members of the PPG. We also collected 48 CQC comment cards which were sent to the practice before the inspection for patients to complete.

The vast majority of feedback collected on the day indicated patients were satisfied with the service provided, that they were treated with dignity, respect and care, and that staff were caring,

professional and approachable. This was in line with comments from the NHS England GP Patient Survey from July 2013 - March 2014 which showed higher than average levels of satisfaction for GPs and nurses treating patients with care and respect and involving them in decisions, 91% and 96% respectively. The practice had also undertaken a survey of patients in March 2015 and 92% of the patients who responded stated that GPs and nurses always treated them with respect, compassion and kindness.

The reception desk was shielded by glass partitions which helped keep patient information private. There was a sign asking patients to approach the desk one at a time, to help prevent patients overhearing potentially private conversations between patients and reception staff. There was a separate room where patients could speak in private if they wished.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were in use in treatment and consulting rooms to maintain patients' privacy and dignity during investigations and examinations. There was a chaperone policy and guidelines for staff, and a poster advertising the service in reception. Nursing staff acted as chaperones where requested.

Care planning and involvement in decisions about care and treatment

The templates, on the computer system, were used for people with long term conditions supported staff in helping to involve people in their care. Nursing staff were able to provide examples of where they had discussed care planning and supported patients to make choices about their treatment.

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 and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. The March 2105 patient survey, undertaken by the practice, also reported that 90% of patients felt fully involved in their care and treatment.

People said the GP's explained treatment and results in a way they could understand. They felt able to ask questions and involved in making decisions about their care. Staff told us there was a translation service available for those whose first language was not English and we saw details for this service.

Patient/carer support to cope emotionally with care and treatment

Patients said they were given good emotional support by the doctors. Comment cards filled in by patients said doctors and nurses provided a caring and supportive service.

GP's referred people to bereavement counselling services where necessary. There was also information in reception on help for carers and access to talking therapies.

The practice maintained a register of carers, with the information being recorded in patient notes so extra support could be offered. The practice also kept registers of other groups who may need extra support, such as those receiving palliative care and patients with mental health issues, so extra support could be provided.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood and systems were in place to address identified needs. The practice had information both about the prevalence of specific diseases and the specific population groups in the practice area. This information was reflected in the services provided, for example screening programmes, reviews for patients with long term conditions and those with mental health needs. Longer appointments could be made available for those with complex needs, for instance patients with dementia.

The practice had extended opening hours from 8:00am until 12:30pm on a Saturday for pre-booked appointments. This benefited the working population and parents with children of school age. The practice also provided the option of telephone consultations with GPs and nursing staff. It also ran flu clinics on a Saturday.

The practice was proactive in monitoring those who did not attend for screening or long term condition clinics and followed these up. The facilities and premises were appropriate for the services which were planned and delivered, with sufficient treatment rooms and equipment available.

The practice had identified that in taking responsibility for patients with learning disabilities, who lived at a residential home, that many had autism and were uncomfortable waiting for their appointments in a busy reception area. The practice had arranged that, if they were called when the patient arrived for their appointment, they would be met at a rear door to avoid them having to wait in reception.

Tackling inequity and promoting equality

The buildings accommodated the needs of people with disabilities. All treatment/consulting rooms and patient toilets were on the ground floor. Disabled parking spaces were available. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. Translation facilities were available for those patients whose first language was not English.

Patient records were noted to highlight to the GPs when someone was living in vulnerable circumstances or at risk so extra support could be offered.

The practice had two male and two female GPs which gave patients to the choices of seeing a male or female GP.

Access to the service

Patients were able to book urgent appointments by contacting the practice at 8.00am in the morning. Routine appointments could be booked up to 12 weeks in advance. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed and details of how to access these were on pre-recorded telephone messages, on the website and in patient information leaflet. Appointments could also be booked on line.

Home visits could be made available where required, for instance for those with mobility issues. Whilst we were inspecting the practice one of the GPs made an urgent home visit. Repeat prescriptions could be ordered online and this was highlighted on the website and in the patient information leaflet.

The practice was open from 8:00am to 6:00pm on Monday to Friday, we were told that if appointments were needed either before or after surgery the GPs would accommodate these. The practice also opened between 8:00am to 12:30pm on a Saturday. The GP's had a rota for the surgery on a Saturday, this meant that patients could get an appointment with the GP of their choice. Opening times and closures were advertised on the practice website and in the information leaflet.

The practice had made a commitment, both on the website and in patient information leaflets that they would always see patients under 12 on the same day.

During core times patients could access doctors, nurses and health care assistants. The most common negative comment from patients was the time they had to wait to get non urgent appointments. The practice was aware of the issue and was monitoring the use of appointments and telephone consultations to minimise delays.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in

Good

Are services responsive to people's needs?

(for example, to feedback?)

England and there was a designated responsible person who handled all complaints in the practice. Information on how to complain was displayed in reception. Staff were aware of the complaints process. The practice also provided a leaflet for patients on complaints, which was available in reception. The leaflet contained details of the process within the practice and also contact information for the Independent Complaints Advisory Service, the South Tees Clinical Commissioning Group and the Parliamentary and Health Service Ombudsman.

We looked at a summary of complaints from the last 12 months, and could see that these had been responded to with a full explanation and apology. The practice summarised and discussed complaints with staff at meetings. Some complaints were also raised as significant events and investigated and changes made to medications or practice. People we spoke to said they would feel comfortable raising a complaint if the need arose.

There was a suggestion box in reception where patients could leave feedback.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to ensure that they offered patients the care they needed in the most appropriate way. The partners work as a united team sharing responsibility and leading by example in delivering the best services for patients. This approach included encouraging nurses to continue to develop clinical responsibility for areas of chronic disease management and also ensured that administrative members of the team are qualified for the role they undertook.

All the staff we spoke to knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff also felt that they were consulted and their opinion was valued.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. Staff were aware of the policies and how to access them.

Staff were clear on their roles and responsibilities and were able to communicate with doctors or managers if they were asked to do something they felt they were not competent in. A number of staff had specific lead roles such as management of specific conditions.

The practice used the Quality and Outcomes Framework (QOF) to measure performance. The QOF data for this practice showed it was performing in line or above national standards in most areas. The practice regularly reviewed its results and considered how to improve. The practice had identified lead roles for areas of clinical interest and safeguarding. The GPs undertook their own programme of clinical audit and these results were discussed at clinical meetings.

Information and learning from incidents and complaints was also evaluated and reported to staff in the practice.

Leadership, openness and transparency

Staff said they felt happy to work at the surgery and that they were supported to deliver a good service and good standard of care. Staff described the culture at the practice as open and honest and said they felt confident in raising concerns or feedback. Our review of the complaints and incidents log confirmed that both administrative and clinical staff had raised issues.

Staff within the practice felt supported by their managers and the GPs. There was also a clear structure which set out both organisational and clinical lines of accountability.

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

There was an active PPG and actions were published on the practice website for the practice population to read. This included undertaking a survey of patients who used repeat prescriptions and taking forward actions based on the findings such as raising awareness of the availability of on line ordering for repeat prescriptions. The PPG had also led on the updating of a range of practice leaflets and revising the practice website, to make both more user friendly for patients.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We saw that all the doctors and relevant staff were able to access protected learning time where necessary. We saw that appraisals took place where staff could identify learning objectives and training needs.

The practice had completed reviews of significant events and other incidents, and shared these with staff via team meeting discussions to ensure the practice improved outcomes for patients.