Dr Thorniley-Walker and Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Thorniley-Walker and Partners on 16 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the following population groups: Older people; People with long-term conditions; Families, children and young people; Working age people (including those recently retired and students); People whose circumstances may make them vulnerable; People experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The majority of patients said they were able to get an appointment with a GP when they needed one, with urgent appointments available the same day.
- The practice offered pre-bookable early evening and early morning appointments two days per week, which improved access for patients who worked full time.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure in place and staff felt supported by management. The practice proactively sought feedback from staff and patients, which they acted on.

Summary of findings

- Staff throughout the practice worked well together as a team.

We saw an area of outstanding practice:

- Significant event meetings were held on a quarterly basis; chaired each time by a different GP, to promote transparency and ensure all were involved. Prior to each meeting the chair would review the reported incidents and appoint a score to each one. The score then determined the action to be taken, for example, whether to carry out a full review or share any learning points. In addition to the incidents reported by staff, the practice manager also considered any negative reviews on patient websites to be significant events. The issues were logged and discussed as with any other event.

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

The provider should:

- Maintain clear records on prescription stationery stock, in line with guidance from NHS Protect;
- Carry out a risk assessment to determine which emergency drugs are required by the practice, and document the findings.

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.

The nationally reported data we looked at as part of our preparation for this inspection did not identify any risks relating to safety. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The practice used every opportunity to learn from incidents to support improvement. Information about safety was highly valued and was used to promote learning and improvement.

Risks to patients were assessed and well managed. Disclosure and Barring Service (DBS) checks had been completed for all staff that required them. Good infection control arrangements were in place and the practice was clean and hygienic. Although good medicines management arrangements were in place, the practice did not maintain clear records on prescription stationery stock. Some of the emergency medicines identified by the CQC, in its advice to practices, were not stocked at the practice.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were above national averages. The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring its effectiveness and had achieved 98.7% of the points available. This was above the local and national averages of 95.3% and 93.5% respectively. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. Staff worked with multidisciplinary teams which helped to provide effective care and treatment. Staff had access to the information and equipment they needed to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

Patients said they were treated with compassion, dignity and respect. Patient's privacy and confidentiality was respected. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect.

The National GP Patient Survey from January 2015 showed the majority of patients were happy with the care received. 92% and 87% respectively of patients said they had confidence and trust in their GP and nurse (compared to 93% and 86% nationally). However, 83% said the last GP they saw or spoke to was good at listening to them (compared to the national average of 88%) and 61% said the last nurse they saw or spoke to was good at involving them in decisions about their care (national average 74%).

The practice had arrangements in place to support patients and their families during times of bereavement.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Nationally reported data showed patient outcomes were broadly in line with the local Clinical Commissioning Group (CCG) and national averages. Findings from the National GP Patient Survey, published in January 2015, showed most patients were satisfied with telephone access (83% of patients said this was easy or very easy, compared to the national average of 71% and a CCG average of 80%). The survey showed that 95% of patients felt their appointment was convenient (compared the national average of 92% and CCG average of 93%).

Some of the patients we spoke with told us they felt they had to wait too long for an appointment. Of patients who responded to the survey, 72% said they were able to get an appointment or speak to someone when necessary. This was below the local CCG average (76%) and slightly below the national average (73%). However, we saw the next available pre-bookable appointment was for the following day and there was no limit on the number of emergency appointments each day. Therefore patients could be seen on the same day where necessary.

Patients were able to book longer appointments on request and pre-bookable appointments with a GP were available early mornings and early evenings two days per week. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Summary of findings

Are services well-led?

Good

The practice is rated as good for providing well-led services.

There was a clear, documented mission statement. Staff were clear about their responsibilities in relation to the practice aims and objectives. There was a clear leadership structure in place with designated staff in lead roles and staff said they felt supported by management. Team working within the practice between clinical and non-clinical staff was good.

The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which they acted on. The practice had an active patient participation group (PPG), although none of the patients we spoke with on the day of the inspection were aware of the PPG. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with heart failure. This was 2.0 percentage points above the local Clinical Commissioning Group (CCG) average and 2.9 points above the England average.

The practice offered personalised care to meet the needs of the older people in its population. The practice had written to patients over the age of 75 years to inform them who their named GP was. The practice was responsive to the needs of older people, including offering home visits. Staff within the practice worked closely with other health professionals to provide care and support for older people. Arrangements had been made for the district nursing team to undertake home visits to carry out routine checks for patients who were housebound. The practice maintained a palliative care register and offered immunisations for pneumonia and shingles to older people.

People with long term conditions

Good

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

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. Patients with long-term conditions such as hypertension and diabetes, were invited to attend a structured annual review to check that their health and medication needs were being met, or more often where this was judged necessary by the GPs. Longer appointments and home visits were available when needed. The practice's electronic system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively.

Nationally reported QOF data (2013/14) showed the practice had achieved good outcomes in relation to the conditions commonly associated with this population group. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with epilepsy This was 11.4 percentage points above the local CCG average and 10.6 points above the national average.

Summary of findings

Families, children and young people

Good

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

The practice had identified the needs of families, children and young people, and put plans in place to meet them. We saw the practice had processes in place for the regular assessment of children's development. This included the early identification of problems and the timely follow up of these. Systems were in place for identifying and following-up children who were considered to be at-risk of harm or neglect. For example, the needs of all at-risk children were regularly reviewed at practice multidisciplinary meetings involving child care professionals such as health visitors.

Appointments were available outside of school hours and the premises were suitable for children and babies. Arrangements had been made for new babies to receive the immunisations they needed. Vaccination rates for 12 month and 24 month old babies and five year old children were in line with the local CCG area.

Pregnant women were able to access an antenatal clinic provided by healthcare staff attached to the practice. The practice had obtained 100% of the QOF points available to them for providing recommended maternity services and carrying out specified child health surveillance interventions. Nationally reported QOF data (2013/14) showed antenatal care and screening were offered in line with current local guidelines. The data also showed that child development checks were offered at intervals consistent with national guidelines. Cervical screening rates (82.2%) were in line with the national average (81.9%).

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible and flexible. The practice offered some online services as well as a full range of health promotion and screening which reflected the needs for this age group.

Patients could order repeat prescriptions and book appointments on-line. Early morning (between 7.00am and 8.00am) appointments were available two mornings per week. The practice was also open between 6.00pm and 7.00pm two evenings a week).

Summary of findings

Telephone consultations with clinicians could also be booked on a daily basis. This made it easier for people of working age to get access to the service. NHS health checks were offered to patients between the ages of 40 and 74 and the practice also carried out joint injections as part of its minor surgery service.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances, including those with a learning disability. Patients with learning disabilities were invited to attend the practice for annual health checks. The practice offered longer appointments for people with a learning disability, if required.

The practice had effective working relationships with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

One of the GPs had achieved a diploma in substance misuse and provided information and support to patients. Specialist drug and alcohol sessions were held each week in the practice.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

The practice worked closely with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had care plans in place for patients with dementia. Patients experiencing poor mental health were sign posted to various support groups and third sector organisations.

Nationally reported QOF data (2013/14) showed the practice had achieved good outcomes in relation to patients experiencing poor mental health. For example, the practice had obtained 99.5% of the points available to them for providing recommended care and treatment for patients with poor mental health. This was 9.7 percentage points above the local CCG average and 9.1 points above the England average. The practice kept a register of patients with mental health needs which was used to ensure they received relevant checks and tests.

Summary of findings

What people who use the service say

We spoke with 14 patients during our inspection. We spoke with people from different age groups, who had varying levels of contact and had been registered with the practice for different lengths of time.

We reviewed four CQC comment cards which had been completed by patients prior to our inspection.

Most patients were complimentary about the practice, the staff who worked there and the quality of service and care provided. They told us the staff were very caring and helpful. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were generally happy with the appointments system, although some felt it sometimes took too long to wait for an appointment.

The latest National GP Patient Survey published in January 2015 showed the large majority of patients were satisfied with the services the practice offered. The results were either in line with or above the national averages:

- GP Patient Survey score for opening hours – 77% (national average 76%);
- Percentage of patients rating their ability to get through on the telephone as very easy or easy – 83% (national average 71%);
- Percentage of patients rating their experience of making an appointment as good or very good – 79% (national average 73%);
- Percentage of patients rating their practice as good or very good – 86% (national average 86%);
- The proportion of patients who would recommend their GP surgery – 78% (national average 78%).

Areas for improvement

Action the service SHOULD take to improve

- Maintain clear records on prescription stationery stock, in line with guidance from NHS Protect;
- Carry out a risk assessment to determine which emergency drugs are required by the practice, and document the findings.

Outstanding practice

Significant event meetings were held on a quarterly basis; chaired each time by a different GP, to promote transparency and ensure all were involved. Prior to each meeting the chair would review the reported incidents and appoint a score to each one. The score then determined the action to be taken, for example, whether to carry out a full review or share any learning points. In addition to the incidents reported by staff, the practice manager also considered any negative reviews on patient websites to be significant events. The issues were logged and discussed as with any other event.

Dr Thorniley-Walker and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Thorniley-Walker and Partners

The Dr Thorniley-Walker and Partners practice is registered with the Care Quality Commission to provide primary care services. It is located in the Boldon Colliery area of South Tyneside.

The practice provides services to around 6,450 patients from one location. The Medical Centre, Gibson Court, Boldon Colliery, Tyne and Wear, NE35 9AN. We visited this address as part of the inspection. The practice has three GP partners and two salaried GPs (three female and two male doctors), a nurse practitioner and a practice nurse (both female), a healthcare assistant, a practice manager, and nine staff who carry out reception and administrative duties.

The practice is part of South Tyneside clinical commissioning group (CCG) and is a training practice. The practice is situated in an area of relatively low levels of deprivation. The practice population is made up of a slightly higher than average proportion of patients over the age 65 (19.7% compared to the national average of 16.7%).

The practice is located in a purpose built two storey building. All patient facilities are on the ground floor. There is on-site parking, disabled parking, a disabled WC, wheelchair and step-free access.

Surgery opening times at the practice are between 8:30am and 5:30pm Monday to Friday, with extended hours on Mondays and Thursdays between 6:00pm and 7:00pm and between 7:00am and 8:00am on Tuesdays and Wednesdays. Patients can book appointments in person, on-line or by telephone.

The practice provides services to patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

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

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider is

meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

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

As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local clinical commissioning group (CCG).

We carried out an announced visit on 16 June 2015. We spoke with 14 patients and nine members of staff from the practice. We spoke with and interviewed four GPs, the nurse practitioner, the practice manager and three staff carrying out reception, administrative and dispensing duties. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed four CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe track record

The practice had a good track record for maintaining patient safety.

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how the practice operated. Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards reflected this. We (CQC) had not received any safeguarding concerns regarding patients who used the practice. We met with the local clinical commissioning group (CCG) before we inspected the practice and they did not raise any concerns with us.

As part of our planning we looked at a range of information available about the practice. This included information from the Quality and Outcomes Framework (QOF) and the National Patient Survey. The latest information available to us indicated there were no areas of concern in relation to patient safety.

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety.

We saw that records were kept of significant events and incidents. We reviewed a sample of the reports completed by practice staff during the previous 12 months, and the minutes of meetings where these were discussed. The records looked at showed the practice had managed such events consistently and appropriately during the period concerned and this provided evidence of a safe track record for the practice.

Learning and improvement from safety incidents

The practice was open and transparent when there were near misses or when things went wrong. There was a robust system in place for reporting, recording and monitoring significant events. We spoke with the GPs about the arrangements in place. They told us that all staff had responsibility for reporting significant or critical events.

Managers said the process was used to support, learn and improve, not to blame. Staff were aware of the system for raising issues to be considered and felt encouraged to do so. The practice also reported significant events to the local clinical commissioning group (CCG), using the local safeguarding incident risk management system (SIRMS).

Records of those incidents were kept on the practice computer system and made available to us. We found details of the event, steps taken, specific action required and learning outcomes and action points were noted.

There was evidence that significant events were discussed at staff meetings to ensure learning was disseminated and implemented. Significant event meetings were held on a quarterly basis; chaired each time by a different GP, to promote transparency and ensure all were involved. Prior to each meeting the chair would review the reported incidents and appoint a score to each one. The score then determined the action to be taken, for example, whether to carry out a full review or share any learning points.

We saw there had been a significant event in relation to some incorrect vaccines being administered. We saw evidence that a thorough investigation had taken place. This had identified some key learning points, which had been shared with the relevant staff. The event had been discussed within the practice and protocols were revised to prevent the incident from happening again. The changes were implemented and the practice told us they would be reviewed at a later date to confirm they remained effective.

In addition to the incidents reported by staff, the practice manager also considered any negative reviews on patient websites to be significant events. The issues were logged and discussed as with any other event. We saw one example of a negative review about a patient consultation being interrupted. The issue was discussed and actions agreed to help ensure this did not happen again.

There were some significant events where feedback was supplied to other agencies. For example, a patient had been discharged to a nursing home which was not in the practice area. The patient had been unable to register with another GP, so the practice carried out a home visit. This was fed back to other services, including the local CCG.

We discussed the process for dealing with safety alerts with the GPs and the practice manager. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. Arrangements had been

made which ensured national patient safety alerts were disseminated by the practice manager to all of the GPs. This enabled the clinical staff to decide what action should be taken to ensure continuing patient safety, and mitigate risks. The GPs signed the alert to show they had read it. There was a designated standing agenda item on safety alerts at the weekly clinical meetings. Any alerts were discussed to ensure staff were aware of any necessary action. We saw minutes confirming these discussions had taken place. For example, on receipt of safety advice about the use of a particular type of medicine, the practice reviewed patients taking this medicine long-term and removed it from their prescription where this was judged appropriate.

Reliable safety systems and processes including safeguarding

The practice had effective systems in place to manage and review risks to vulnerable children, young people and adults. Safeguarding policies and procedures were in place. These provided staff with information about safeguarding legislation and how to identify, report and deal with suspected abuse. Information about how to report safeguarding concerns and contact the relevant agencies was easily accessible.

There were identified members of staff with clear roles to oversee safeguarding within the practice. Staff we spoke with said they knew which of the GP partners was the safeguarding lead. The practice manager was the deputy lead. The GP and practice manager were responsible for ensuring staff were aware of any safeguarding cases or concerns.

There was a system on the practice's electronic records to highlight vulnerable patients. Children and vulnerable adults who were assessed as being at risk were identified using READ codes. These codes alerted clinicians to their potential vulnerability (clinicians use READ codes to record patient findings and any procedures carried out). This system was very comprehensive; the practice had developed a number of specific codes to ensure they were aware of the specific concerns for each individual.

The clinicians discussed ongoing and new safeguarding issues at their weekly meetings. The local district nurses attended also attended these meetings. The practice had identified that there was a lack of information shared with GP practices about school age children as the school nurses did not attend the safeguarding meetings. Staff had been proactive and taken steps to discuss with the health visiting team whether this could be arranged.

The staff we spoke with had a good knowledge and understanding of the safeguarding procedures and what action should be taken if abuse was witnessed or suspected. Staff were able to describe the action they had taken in relation to a recent safeguarding referral.

We saw records which confirmed all relevant staff had attended training on safeguarding children. All of the GPs had completed child protection training to level three. This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns. Practice nurses had completed level two which is more relevant to the work they carry out whilst all other staff attended level one training sessions. This was confirmed by the staff we spoke with.

The practice had a chaperone policy. We saw posters on display in the consultation rooms to inform patients of their right to request a chaperone. Staff told us that currently only a practice nurse undertook this role. The nurse we spoke with was clear about the requirements of the role and had undergone Disclosure and Barring Service (DBS) checks.

An up to date whistleblowing policy was in place. Staff we spoke with were all able to explain how, and to who, they would report any such concerns. They were all confident that concerns would be acted upon.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerator and found they were stored securely and were only accessible to authorised staff.

There was a clear policy for ensuring medicines were kept at the required temperatures (for example, some vaccines needed to be stored in a refrigerator). The policy described the action to take in the event of a potential failure of the refrigerator. Staff confirmed the procedure was to check the refrigerator temperature every day to ensure the vaccines were stored at the correct temperature. We saw records of the daily temperature recordings, which showed the correct temperatures for storage were maintained.

We checked medicines stored in the treatment rooms and found they were stored securely and were only accessible

to authorised staff. However, the key to the fridges was kept next to one of the fridges in an unlocked cupboard. The area was accessible to all visitors to the practice so there was a security risk. The practice manager told us the key would be removed and stored securely.

There were systems in place to ensure GPs regularly monitored patients medicines and re-issuing of medicines was closely monitored, with patients invited to book a 'medication review', where required. There was a designated member of staff within the administrative team who carried our regular checks on review due dates. They then sent a 'task' within the computer system to the relevant to GP so they could confirm whether the patient did need a review. If that was the case then the administration team would contact the patient and ask them to make an appointment. Regular audits were carried out on review dates to ensure patients medicines were checked appropriately.

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

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol covered, for example, how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. The computer system had been set up to prevent prescriptions being automatically re-issued if a patient had not been reviewed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescriptions were securely stored at all times. However, we saw records of blank prescription form serial numbers were not made on receipt into the practice or when the forms were issued to GPs. This is contrary to guidance issued by NHS Protect, which states that 'organisations should maintain clear and unambiguous records on prescription stationery stock'.

Cleanliness and infection control

We saw the practice was clean, tidy and well maintained. Patients we spoke with told us they were happy with the cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this.

The nurse practitioner was the nominated infection control lead. We saw there was an up to date infection prevention and control policy and detailed guidance for staff about specific issues. For example, handling specimens and minor operations. All of the staff we spoke with about infection control said they knew how to access the practice's infection control procedures. Staff attended annual training courses on infection control.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. The treatment and nurses rooms had flooring that was impermeable, and easy to clean. The privacy curtains in the consultation rooms were changed every six months or more frequently if necessary. We saw records were maintained so staff knew when they were due to be changed.

The practice employed a domestic to carry out cleaning duties. We looked at records and saw they completed cleaning schedules, on a daily, weekly, monthly and annual basis. The nurse practitioner carried out regular audits to check on the cleanliness of the building.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We looked at some of the practice's clinical waste and sharps bins located in the consultation rooms. All of the clinical waste bins we saw had the appropriately coloured bin liners in place and all of the sharps bins we saw had been signed and dated as required. We saw there were spillage kits (these are specialist kits to clear any spillages of blood or other bodily fluid) located throughout the building.

Staff were protected against the risk of health related infections during their work. We asked the reception staff about the procedures for accepting specimens of urine from patients. They showed us there were bags for patients to put their own specimens in. The nurses then wore PPE when transferring the specimens for testing.

A legionella risk assessment had been completed (legionella is a type of bacteria found in the environment which can contaminate water systems in buildings and can be potentially fatal). This had identified that a shower used by staff should be run every day for a number of minutes.

Good

Are services safe?

Staff told us the cleaning staff carried this out. These checks were not documented; however, the practice manager told us they would add the task to the cleaning schedules.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment; for example, weighing scales and blood pressure monitoring equipment. Fire extinguishers were serviced regularly. The practice maintained records showing when the next service was due.

Staffing and recruitment

The practice had an up to date recruitment policy in place that set out the standards they followed when recruiting staff.

We looked at three of the personnel files. We saw that pre-employment checks, such as obtaining a full work history, evidence of identity and references had been carried out, prior to staff starting work for two out of the three staff. However, one of the staff files we looked at did not contain hard copies of proof of identification. The practice manager told us they would ensure that proof was obtained.

The practice manager and all staff that were in direct contact with patients had been subject to DBS checks. The GPs had undergone DBS checks as part of their application to be included on the National Medical Performers' List. All performers are required to register for the online DBS update service which enables NHS England to carry out status checks on their certificate. The practice had carried out a risk assessment which had determined that none of the administrative staff required a DBS check.

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

Staff we spoke with were flexible in the tasks they carried out. This demonstrated they were able to respond to areas in the practice that were particularly busy. For example, by working on the front reception desk receiving patients or by answering the telephones. Staff told us there was always enough staff on duty to maintain the smooth running of the practice and ensure patients were kept safe.

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff and patients to see.

The practice manager showed us a number of risk assessments which had been developed and undertaken; including a fire risk assessment. Risk assessments of this type helped to ensure the practice was aware of any potential risks to patients, staff and visitors and planned mitigating action to reduce the probability of harm.

The practice had systems in place to manage and monitor health and safety. The fire alarms and emergency lights were regularly tested. There were annual fire evacuation drills. We saw records confirming these checks had been carried out. An evaluation of each evacuation was carried out, for example, the time taken to evacuate was recorded.

There were clear lines of accountability for all aspects of patient care and treatment. The GPs each had lead roles such as safeguarding and infection control lead. Each clinical lead had systems for monitoring their areas of responsibility.

Appropriate staffing levels and skill-mix were provided by the practice during the hours the service was open.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). The defibrillator was accessible and staff carried out regular checks on the battery and the associated equipment. All staff we spoke with regarding emergency procedures knew the location of this equipment.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. We found all emergency medicines were in date. The practice had three emergency medicines kits which could be accessed by the GPs carrying out home visits. We checked these and found that some of the medicines identified by the CQC, in its advice to practices, were not included. Staff told us that careful consideration had been given to what should be included and why. They told us they had followed guidelines from the UK Resuscitation Council and the emergency medicines stocked were appropriate. However, this had not been formally documented.

Staff attended annual fire safety training and a member of the team was a designated fire warden.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Copies of the plans were held by the practice manager and assistant practice manager off site, so contact details were available if the buildings were not accessible.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could describe the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE). We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs and these were reviewed when appropriate.

GPs and nurses led in specialist clinical areas such as diabetes. GP leads had overall responsibility for ensuring the disease or condition was managed effectively in line with best practice. Nursing staff were jointly responsible with GPs for ensuring the day-to-day management of a disease or condition was in line with practice protocols and guidance. Clinical staff we spoke with said they would not hesitate to ask for or provide colleagues with advice and support. Staff had access to the necessary equipment and were skilled in its use; for example, blood pressure monitoring equipment.

We spoke with staff about how the practice helped people with long term conditions manage their health. They told us that there were regular clinics where patients were booked in for recall appointments. This ensured patients had routine tests, such as blood or spirometry (lung function) checks to monitor their condition. In addition to this, the practice had signed up to an initiative with the local CCG whereby district nurses would carry out checks for patients who were housebound.

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

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

Management, monitoring and improving outcomes for people

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

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

The practice had a system in place for completing clinical audit cycles, which led to improvements in clinical care. We saw a number of clinical audits had recently been carried out. The results and any necessary actions were discussed at the clinical team meetings. This included an audit of patients with gout who had received screening for heart disease. An initial audit was carried out which showed that 23% of patients had been offered an assessment. Action was taken, including adding a reminder note to patient records. A further audit was carried out and this showed an improvement, in that 58% of relevant patients had a recorded assessment. Staff told us they wanted to increase this and had planned to carry out a further audit later in 2015.

The practice used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. The Quality and Outcomes Framework is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures. The results are published annually. We saw the practice had achieved a score of 98.7% of the percentage points available to them for providing recommended treatments for the most commonly found clinical conditions. This was above both the local clinical commissioning group (CCG) and England averages (95.3% and 93.5% respectively). Specific examples to demonstrate this included:

Good

Are services effective?

(for example, treatment is effective)

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

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of these patients and their families.

Effective staffing

Practice staffing included medical and dispensing/ administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support. Once a month the practice closed during the afternoon for protected learning time (PLT sessions).

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with NHS England).

Most other staff undertook annual appraisals which identified learning needs from which action plans were documented. Nursing staff were appraised by the nurse practitioner, the nurse practitioner was appraised by GPs, and the practice manager appraised the administrative and support staff. However, the practice manager told us they had not had an appraisal for a number of years. They said they felt supported and were able to raise any learning needs with the GP partners. We saw records in staff files of appraisals completed within the last 12 months.

We saw the practice had an induction programme to be used when staff joined the practice. This covered individual areas of responsibility and general logistical information about how the practice operated. A comprehensive pack had also been developed to support the trainee GPs (GP registrars) with their work. They told us they were provided with a four week induction period. During this time they received close support and supervision from a mentor and had a phased introduction to holding surgeries. Time was set aside to spend with attached health staff, including health visitors and district nurses. Debrief sessions were held after each clinic to review progress and address any concerns. The GP registrar we spoke with confirmed they had a strong working relationship with their mentor.

Staff were proactively supported to acquire new skills and share best practice. For example, one of the doctors was a GPwSI (GP with a Special Interest) in musculo-skeletal medicine; this meant they were able to carry out joint injections at the practice, rather than having to refer patients to other services. Another of the GPs had achieved a diploma in palliative care and in substance misuse.

Nursing staff had defined duties they were expected to carry out and were able to demonstrate they were trained to fulfil these duties. For example, the nurse practitioner said they carried out contraceptive implant fittings and had been trained (with the support of the practice) to do so.

The administrative and support staff had clearly defined roles, however they were also able to cover tasks for their colleagues. This helped to ensure the team were able to maintain levels of support services at all times, including in the event of staff absence and annual leave.

Working with colleagues and other services

The practice had positive working relationships and had forged close links with other health and social care providers, to co-ordinate care and meet patients' needs.

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

We found appropriate end of life care arrangements were in place. The practice had implemented a proforma to complete at end of life care meetings; the information gathered was then copied directly into the relevant patient

Good

Are services effective?

(for example, treatment is effective)

record. There were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider and the ambulance service.

Information sharing

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

There were systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff had been fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Regular meetings were held throughout the practice. Information about risks and significant events were shared openly at meetings. Patient specific issues were also discussed to enable continuity of care.

Correspondence from other services such as blood results and letters from the local hospital including discharge summaries, was received both electronically and by post. Staff we spoke with were clear about their responsibilities for reading and taking action to address any issues arising from communications from other care providers. They understood their roles and how the practice's systems worked.

Consent to care and treatment

Before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes.

We found that staff were aware of the Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and their duties in fulfilling it. Some staff had recently attended some CCG training sessions on consent and the MCA . All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. They also demonstrated an understanding of Gillick competencies (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).

There was a practice policy, although this was not formally documented, for recording consent for specific interventions. For example, verbal consent was taken from patients for routine examinations and verbal and implied consent for the measurement of blood pressure. We saw written consent had been obtained where necessary, for example, for contraceptive implants.

Health promotion and prevention

The practice identified people who needed ongoing support and were proactive in offering this. This included carers, those receiving end of life care and those at risk of developing a long term condition. For example, there was a register of all patients with asthma. Nationally reported QOF data (2013/14) showed that the practice had obtained 100% of the points available to them for providing recommended clinical care and treatment to asthma patients. The data indicated that 84.6% of patients on the register had a face-to-face annual review in the preceding 12 months. This was 7.0 percentage points above the local CCG average and 9.1 points above the England average.

The QOF data showed the practice obtained 100% of the points available to them for providing cervical screening to women. This was 2.5 percentage points above both the local CCG and England averages The practice had procedures in place for the management of cervical screening. The proportion of patients eligible for screening who had been tested was 82.2%, this was in line with the local and national averages.

We found patients with long-term conditions were recalled to check on their health and review their medicines for effectiveness. The practice's electronic system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. Staff said this worked well and helped to prevent any patient groups from being overlooked.

New patients were offered a 'new patient check', to ascertain details of their past medical histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g. smoking, alcohol intake, blood pressure, height and weight).

Good

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for babies and children, as well as travel and flu vaccinations, in line with current national guidance. Vaccination rates for 12 month and 24 month old babies and five year old children were in line with other practices in the local CCG area.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it.

There was a range of information on display within the waiting room. This included a number of health promotion and prevention leaflets. The practice's website included links to a range of patient information, including for family health, long term conditions and minor illnesses

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice regarding patient satisfaction. This included information from the national GP survey (January 2015). The scores in relation to patients' last appointment with a doctor or nurse were generally in line with national averages, although the proportion of patients who said the nurse treated them with care and concern was below average. For example:

- 92% of patients said they had confidence and trust in their GP (compared to 93% nationally)
- 87% of patients said they had confidence and trust in their nurse (compared to 86% nationally)
- 80% of patients said the GP treated them with care and concern (82% nationally)
- 73% of patients said the nurse treated them with care and concern (compared to 78% nationally).

We spoke with 14 patients during our inspection and reviewed four CQC comment cards which had been completed by patients prior to the inspection. The majority of patients were happy with the care they received from the practice and said their dignity and privacy was respected. Most patients commented that the practice provided a very good service.

Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and conversations taking place in those rooms could not be overheard.

The reception area opened directly onto the patient waiting area. We saw staff who worked in this area made every effort to maintain patients' privacy and confidentiality. Staff were aware of how to protect patients' confidential information. There was a room available if patients wanted to speak to the receptionist privately.

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

Staff were aware of the need to keep records secure. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation. Information regarding patient confidentiality was contained within the practice information leaflet.

The practice had policies in place to ensure patients and other people were protected from disrespectful, discriminatory or abusive behaviour. The staff we spoke with were able to describe how they put this into practice.

Care planning and involvement in decisions about care and treatment

Patients told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them time to ask questions and responded in a way they could understand. Patients were satisfied with the level of information they had been given.

The results of the National GP Patient Survey from January 2015 showed most patients felt involved in their care and treatment. However, the proportion of patients who felt the nurse involved them in decisions was below average:

- 83% said the last GP they saw or spoke to was good at listening to them (national average 88%)
- 79% said the last GP they saw or spoke to was good at involving them in decisions about their care (national average 74%)
- 75% said the last nurse they saw or spoke to was good at listening to them (national average 79%)
- 61% said the last nurse they saw or spoke to was good at involving them in decisions about their care (national average 67%).

The practice had identified its most at risk and vulnerable patients. They had signed up to the enhanced service (services which require an enhanced level of service provision beyond the practice's contractual obligations, for which they receive additional payments) for 'Avoiding Unplanned Hospital Admissions' and were completing the work associated with this service. Around 130 patients had been originally identified as being at high risk of hospital admission. The practice had contacted these patients and

with their involvement and agreement, had put agreed plans of care in place. The GPs we spoke with described some examples of care plans agreed with a number of at risk patients.

We saw that access to interpreting services was available to patients, should they require it. Staff we spoke with said the practice did not have many patients whose first language was not English. They said when a patient requested the use of an interpreter, a telephone service was available. There was also the facility to request translation of documents should it be necessary to provide written information for patients.

Patient/carer support to cope emotionally with care and treatment

Most of the patients we spoke with on the day of our visit told us staff responded compassionately when they needed help and provided support when required. For example, patients commented that staff were caring and took time to help and support them.

We saw there was a variety of information on display throughout the practice. This included a patient information leaflet, which contained details about the practice and the services on offer. Notices in the patient waiting room signposted patients to a number of support groups and organisations. The practice website included information to support its patients.

The practice routinely asked patients if they had caring responsibilities. The practice had recently set up a carer's register to help them identify carers and make sure they were aware of the professional support available.

Support was provided to patients during times of bereavement. Staff told us that if families had suffered bereavement, this was followed up by the practice, with either a visit or telephone call depending upon the circumstances. Clinical staff referred patients struggling with loss and bereavement to support groups who provided these types of services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to the needs of the local population. The majority of patients we spoke with and those who filled out CQC comment cards said they felt the practice was meeting their needs. For example, patients could access appointments face-to-face in the practice, receive a telephone call back from a clinician or be visited at home.

Where patients were known to have additional needs, such as being hard of hearing, were frail, or had a learning disability this was noted on the patient's medical record. This meant the GP would already be aware of this and any additional support could be provided, for example, a longer appointment time.

Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the National GP Patient Survey from January 2015 reflected this; 86% (86% nationally) of patients thought the doctors gave them enough time.

The Quality and Outcomes Framework (QOF) data (2013/14) showed the practice had obtained 100% of the points available to them for providing recommended care and treatment to patients needing palliative care (this was in line with the local average and 3.3 percentage points above the national average). The practice 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. QOF data 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. Staff told us these meetings included relevant healthcare professionals involved in supporting patients with palliative care needs, such as community nurses and health visitors.

The practice had identified the needs of families, children and young people, and plans put in place to meet them. Pregnant women were able to access an antenatal clinic provided by healthcare staff attached to the practice. The practice had obtained 100% of the QOF points available to them for providing recommended maternity services and carrying out specified child health surveillance interventions.

All patients had a named GP but the practice was keen to ensure patients were aware they could see any GP of their choice. This was outlined on the website and in the practice leaflet.

The practice engaged regularly with the clinical commissioning group (CCG) and other practices across South Tyneside to discuss local needs and service improvements that needed to be prioritised. Several schemes had been piloted within the practice; this included the Integrated Clinical System (ICE) for obtaining blood test results electronically. The practice was an early implementer of the CCG wide computer system and of the electronic patient discharge in conjunction with the local hospital.

We found that the practice worked collaboratively with other agencies, regularly updating shared information to ensure good, timely communication of changes in care and treatment. Regular internal as well as multidisciplinary meetings were held to discuss patients and their families' care and support needs.

The practice had established a Patient Participation Group (PPG) to help them to engage with a cross section of the practice population and obtain patient views. A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice.

We spoke with three members of the PPG; they explained their role and how the group worked with the practice. The representatives told us the PPG had a good working relationship with the practice, and felt that the GPs listened to them and were very receptive to their ideas. For example, the PPG and practice had recently worked together to promote the use of the on-line appointment booking facility. This work was ongoing and we saw evidence of posters in the waiting room advertising the service.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, opening times had been extended to provide pre-bookable early morning

Good

Are services responsive to people's needs?

(for example, to feedback?)

and evening appointments with a GP two days per week. This information was displayed on the practice's website to keep patients informed. This helped to improve access for those patients who worked full time.

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

Staff at the practice recognised that patients had different needs and wherever possible were flexible to ensure their needs were met. There was a system in place to alert staff to any patients who might be vulnerable or who had special needs, such as patients with poor mental health or a learning disability. Where patients were identified as carers we saw that information was provided to ensure they understood the various avenues of support available to them should they need it. Registers were maintained, which identified which patients fell into these groups. The practice used this information to ensure patients received regular healthcare reviews and access to other relevant checks and tests. Some patients had been identified as always needing longer appointments and the system in place ensured that staff were alerted to this need.

The premises and services had been adapted to meet the needs of people with disabilities. There was currently a bell at the main entrance door that patients who required assistance to access the building could use. We saw that the waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. This made movement around the practice easier and helped to maintain patients' independence. The patient toilets could be accessed by patients with disabilities. Dedicated car parking was provided for patients with disabilities in the car park close to the entrance.

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

Access to the service

Patients were able to book appointments either by calling into the practice, on the telephone or using the on-line system. Face to face and telephone consultations were available to suit individual needs and preferences. Home visits were also made available every day.

The practice was open from 8.30am to 5.30pm Monday to Friday. An early evening surgery with pre-bookable GP appointments was held twice a week, on Mondays and Thursdays. In addition, an early morning surgery was held between 7.00am and 8.00am on Tuesdays and Wednesdays. The practice's extended opening hours two evenings and two mornings per week were particularly useful to patients with work commitments. This was confirmed by patients we spoke with who normally worked during the week.

Emergency, on the day, appointments were available each day. Staff told us there were no limits to these appointments, all patients would be seen in an emergency. The practice also employed a nurse practitioner; they were able to treat minor illnesses and injuries, which was more convenient for patients.

The most recent National GP Patient Survey (January 2015) showed 72% (compared to 73% nationally and 76% locally) of respondents were able to get an appointment or speak to someone when necessary. The practice scored highly on the ease of getting through on the telephone to make an appointment (83% of patients said this was easy or very easy, compared to the national average of 71% and a CCG average of 80%). However, some of the patients we spoke with said they sometimes had to wait too long for an appointment. We looked at the practice's appointments system in real-time on the afternoon of the inspection. The next available appointment with a doctor was on the following morning. In addition, urgent same-day appointments were available to book each day.

We found the practice had an up to date leaflet which provided information about the services provided, contact details and repeat prescriptions. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments online.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was

Good

Are services responsive to people's needs?

(for example, to feedback?)

closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The local out-of-hours provider was Northern Doctors Urgent Care (NDUC).

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 England and there was a designated responsible person who handled all complaints in the practice. Information about services and how to complain was available and easy to understand.

None of the 14 patients we spoke with during the inspection said they had felt the need to complain or raise concerns with the practice. None of the four CQC comment cards completed by patients indicated they had felt the need to make a complaint.

Staff we spoke with were aware of the complaints policy. They told us they would deal with minor matters straight away, but would inform one of the GPs of any complaints made to them. Patients could therefore be supported to make a complaint or comment if they wanted to.

We saw the practice had received five complaints in the last 12 months and these had been investigated in line with the complaints procedure. Where mistakes had been made, it was noted the practice had apologised formally to patients and taken action to ensure they were not repeated. Complaints and lessons to be learned from them were discussed at staff meetings. For example, in one case a medicine had been incorrectly prescribed to a patient with an allergy to it. A review was carried out and steps taken to prevent the same happening again by updating the patient record system. The patient received a full and frank apology.

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 documented mission statement; this was 'to provide accessible, high quality and efficient general practice by combining the benefits of our long standing traditions'. The GP partners had a vision for the future of the practice. This included embracing new technology and taking forward ideas from patients and the service commissioners.

We spoke with a variety of practice staff including the practice manager, GPs, the nurse practitioner and some of the practice's administrative and support staff. They all knew and shared the practice's aims and objectives and knew what their responsibilities were in relation to these. They all told us they put the patients first and aimed to provide person-centred care.

Practice development sessions were held monthly. These meetings were used to review any changes that needed to be made to take account of contractual changes in the GP contract, to reaffirm what the practice did well, what its priorities were, and what changes needed to be made to make further improvements to patient outcomes.

Governance arrangements

Arrangements for assessing, monitoring and addressing risks were in place. For example, the practice had a business continuity plan to help ensure the service could be maintained in the event of foreseeable emergencies. The practice had a number of policies and procedures in place to govern activity. These were available to staff via the shared drive on the computer system. The policies and procedures had been reviewed regularly and were up-to-date. There were arrangements in place for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and actions to mitigate these risks had been put into place.

There was a management team in place to oversee the practice. The practice used the Quality and Outcomes Framework (QOF) as an aid to measure their performance. The practice had achieved an overall QOF score of 98.7% of the maximum points available in 2013/2014; this achievement was above both the local clinical commissioning group (CCG) and the national averages (95.3% and 93.5% respectively). We saw that QOF data was discussed at practice meetings and actions were taken to maintain or improve outcomes. For example, reminders were sent to patients if they failed to respond to the request to attend the practice for reviews of their long-term conditions.

The practice had carried out a number of completed clinical audit cycles, which it used to monitor quality and systems to identify where action should be taken.

Arrangements were in place which supported the identification, promotion and sharing of good practice. For example, a system was in place which ensured significant events were discussed within the practice team. Staff were encouraged and supported to learn lessons where patient outcomes were not of the standard the practice expected. We found that staff felt comfortable to challenge existing arrangements and looked to continuously improve the service being offered.

The practice held regular meetings for staff. These included business meetings between the practice manager and clinicians, weekly clinical meetings, weekly meetings of the practice manager and nursing staff and whole staff meetings at times when the surgery closed for 'protected learning time' (PLT). We looked at minutes from some of these meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

There was a well-established management team with clear allocation of responsibilities. For example, one of the GP partners was the safeguarding lead. The practice manager was responsible for the application of the practice's human resource policies and procedures. We spoke with staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. There were good levels of staff engagement and there was a real sense of team working across all of the staff, both clinical and non-clinical.

We saw that there was strong leadership within the practice and the GPs were visible and accessible. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals.

Are services well-led?

Good

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

We found the practice learned from incidents and near misses. Significant events meetings were held where such issues were discussed. Lessons learned from these discussions were shared with the relevant team members.

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

The practice had made arrangements to seek and act on feedback from patients and staff. The GP partners and practice manager told us they had been proactive in seeking feedback. Patient surveys were sent out to patients each year, in addition to the National GP survey.

There were suggestion boxes in the waiting rooms and there was a patient participation group (PPG) open to all patients. The PPG contained representatives from some of the key population groups. Staff from the practice always attended to support the group. We spoke with three members of the PPG and they felt the practice supported them fully with their work and took on board and acted on any concerns they raised.

NHS England guidance stated that from 1 December 2014, all GP practices must implement the NHS Friends and Family Test (FFT), (the FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices).

We saw the practice had introduced the FFT, there were questionnaires available in the waiting room and instructions for patients on how to give feedback. Results from the FFT were published on the practice's website. Initial results from January to March 2015 showed 86% of patients would be extremely likely or likely to recommend the practice to their friends and family.

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff we spoke with told us their regular meetings provided them with an opportunity to share information, changes or action points. Staff retention was high and they felt involved and engaged in the running of the practice.

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

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance.

Staff told us that the practice was very supportive of training. They said they had received the training they needed, both to carry out their roles and responsibilities and to maintain their clinical and professional development. We saw that regular appraisals took place. Staff from the practice also attended the monthly CCG protected learning time (PLT) initiative. This provided the team with dedicated time for learning and development.

The practice management team met monthly to discuss any significant incidents that had occurred. Reviews of significant events and other incidents had been completed and shared with staff. Staff meeting minutes showed these events and any actions taken to reduce the risk of them happening again were discussed.

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

The practice manager met with other practice managers in the area and shared learning and experiences from these meetings with colleagues. GPs met with colleagues at CCG meetings. They attended learning events and shared information from these with the other GPs in the practice.