Dr Ne Win

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Ne Win on 23 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing 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). It required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they were able to get an appointment with a GP when they needed one, with urgent appointments available the same day.
- The practice offered pre-bookable early evening appointments one day per week with the GP or nurse practitioner, 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 sought feedback from staff and patients, which they acted on.

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

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

The area where the provider must make improvements is:

- The practice must take action to ensure care and treatment is provided in a safe way for service users through the proper and safe management of medicines.

In addition the provider should:

- Ensure that all clinical audits include at least two cycles. The practice should aim to demonstrate an on-going audit programme where they have made continuous improvements to patient care in a range of clinical areas as a result of clinical audit.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. We found significant events were recorded, investigated and learned from. Risks to patients were assessed and well managed. The practice had identified the need to review and update health and safety risk assessments and work was already in progress for this. 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. There were enough staff to keep patients safe. The practice must take action to ensure care and treatment is provided in a safe way for service users through the proper and safe management of medicines.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were in line with national averages. The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring its effectiveness and had achieved 94.5% of the points available. This was just above and the national average of 94%. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

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

Some of the clinical audits we reviewed had been through two audit cycles and some required repeating. The practice should aim to demonstrate an on-going audit programme where they have made continuous improvements to patient care in a range of clinical areas as a result of clinical audit. The practice had achieved slightly lower cervical screening rates (75.2%) compared to the national average (81.9%).

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice in line with or above others for several aspects of care. The results from patients on their

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experiences at their last nurse appointment were more positive than from patients on their experiences at their last GP appointment. For example, the National GP Patient Survey showed 74% of practice respondents said the last GP they saw or spoke to involved them in decisions about their care (local clinical commissioning group (CCG) average 80%; national average 75%). In contrast, 79% said the last nurse they saw or spoke to involved them in decisions about their care (local CCG average 72%; national average 66%).

Patients said they were treated with compassion, dignity and respect and they felt involved in decisions about their care and treatment. A total of 61 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 for 44 patients initially. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained privacy and confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They reviewed the needs of their local population and engaged with the clinical commissioning group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a GP. Patients were able to book longer appointments on request and pre-bookable appointments with a GP or nurse practitioner were available in the evening one day per week. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. We saw the practice had received seven formal complaints in the last 12 months and these had been investigated in line with their 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.

Are services well-led?

Good

The practice is rated as good for being well-led. They had aims and objectives and staff knew what their responsibilities were in relation to these. The practice did not have a formal strategy or business plan in place. Succession planning had been discussed informally, but had not progressed beyond that. The GP and practice manager both said they were aware of the need to formalise these discussions and to plan for the future of the practice.

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

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staff was good. The practice had a number of policies and procedures to govern activity and held regular meetings. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients, which they acted on. The practice did not have an active patient participation group (PPG); however they were taking steps to promote and re-introduce this. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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The six population groups and what we found

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

Older people

Good

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

The practice was linked with a local care home and the GP visited the home at least once per week.

The practice maintained a palliative care register and end of life care plans were in place for those patients it was appropriate for. They offered immunisations for pneumonia and shingles to older people and provided flu vaccinations to people in their own homes if they were housebound.

People with long term conditions

Good

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

Patients with more than one long term condition were offered longer appointment slots. Patients who were unable to attend the practice were visited by the nurse practitioner at home in an attempt to maintain continuity of care. A medicines optimisation pharmacist supported the practice and kept them updated on medication guidelines.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up

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

The practice held a weekly baby clinic and arranged antenatal checks, baby checks, childhood immunisations and mothers' post-natal checks on the same day. A designated member of staff co-ordinated the clinic and all patient appointments. This helped to reduce the need for mothers, babies and young children to attend on more than one occasion. Immunisation rates were generally in line with or slightly higher than the averages for the local CCG. For example, and Men C vaccination rates for one year old children were 96.7% compared to 84.8% across the CCG and Men C Booster vaccination rates for two year old children were 100% compared to 98.2% across the CCG. The practice had achieved slightly lower cervical screening rates (75.2%) compared to the national average (81.9%).

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies.

The nurse practitioner had completed a foundation level sexual health course, followed by the integrated sexual health pathway to degree level. As a result of this, the practice was able to provide a full level two sexual health service. This was particularly relevant to the practice, as their patient list showed they had a young demographic population. They also signposted female patients to a smartphone application which prompted them to take their oral contraceptives and reminded them when their contraceptive injections were due.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible and flexible. The practice offered some online services as well as a full range of health promotion and screening which reflects the needs for this age group. GP appointments could be booked in advance online.

The practice offered extended opening hours one evening per week. Patients could pre-book appointments to see the GP and nurse practitioner at these times. Telephone consultations with clinicians could also be booked on a daily basis. The nurse practitioner ran

Summary of findings

three walk in clinics on a daily basis, as well as offering telephone triage. This made it easier for people of working age to access the service. NHS health checks were offered to patients between the ages of 40 and 74.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances, including those with a learning disability. Patients with learning disabilities were invited to attend the practice for annual health checks. Any patients who failed to attend were followed up by the GP. All of the practice's patients on their learning disability register had received an annual health check last year. The practice offered longer appointments for people with a learning disability, if required.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They made vulnerable patients aware of how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Interpreting services were available for patients whose first language was not English. The practice's patient list included a significant number of patients from within the local Bangladeshi community. The practice had recognised and embraced this and a number of patient information leaflets were available for patients in this language.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people living with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those living with dementia. The practice maintained a register of patients who were living with dementia and invited those patients to attend the practice for annual reviews.

Patients experiencing poor mental health were routinely recalled for an annual check-up by a designated member of the administrative team. Any patients who failed to attend were followed up by the GP.

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The practice had informed patients experiencing poor mental health about how to access various support groups and voluntary organisations. A wide range of leaflets were available in the practice's own patient waiting area for patients to take.	

Summary of findings

What people who use the service say

We spoke with seven patients in total; six patients on the day of the inspection and one before the inspection who had shown an interest in being part of the practice's Patient Participation Group (PPG) in the future. They were mostly complimentary about the services they received from the practice. They told us the staff who worked there were helpful and friendly. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were happy with the appointments system.

We reviewed nine CQC comment cards completed by patients prior to the inspection. All the feedback received on these was complimentary about the practice, staff who worked there and the quality of service and care provided. Of the nine CQC comment cards completed, six patients made direct reference to the caring and respectful manner of the practice staff. Words used to describe the staff and their approach to patients included kind, friendly, helpful, nice people, wonderful, caring, polite and understanding.

The National GP Patient Survey published in January 2015 showed that the practice's results were mixed when compared to other GP practices within the local clinical commissioning group (CCG) area and nationally. The results from patients on their experiences at their last nurse appointment were more positive than from patients on their experiences at their last GP appointment. Some of the results were:

- The proportion of respondents who were able to get an appointment to see or speak to someone the last time they tried – 84% (CCG average 76%, national average 85%);
- The proportion of respondents who said the last GP they saw or spoke to was good at explaining tests and treatments – 77% (CCG 87%, national 82%);
- The proportion of respondents who said the last GP they saw or spoke to was good at involving them in decisions about their care – 74% (CCG 80%, national 75%);
- The proportion of respondents who said they had confidence and trust in the last GP they saw or spoke to – 89% (CCG 94%, national 92%);
- The proportion of respondents who said the last nurse they saw or spoke to was good at explaining tests and treatments – 87% (CCG 81%, national 77%);
- The proportion of respondents who said the last nurse they saw or spoke to was good at involving them in decisions about their care – 79% (CCG 72%, national 66%);
- The proportion of respondents who said they had confidence and trust in the last nurse they saw or spoke to – 94% (CCG 88%, national 86%).

These results were based on 97 surveys that were returned from a total of 422 sent out; a response rate of 23%.

Areas for improvement

Action the service MUST take to improve

The provider must:

- The practice must take action to ensure care and treatment is provided in a safe way for service users through the proper and safe management of medicines.

Action the service SHOULD take to improve

The provider should:

- Ensure that all clinical audits include at least two cycles. The practice should aim to demonstrate an on-going audit programme where they have made continuous improvements to patient care in a range of clinical areas as a result of clinical audit.

Dr Ne Win

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Ne Win

The practice is based within Flagg Court Health Centre in South Shields, Tyne and Wear. The practice serves people living in South Shields itself. The practice provides services to patients from one location: Flagg Court, South Shields, Tyne and Wear, NE33 2LS. We visited this address as part of the inspection.

The practice is located in a purpose built two storey building and provides services to patients at ground floor level. They offer on-site parking including disabled parking, accessible WC's and step-free access. They provide services to just over 1,900 patients of all ages based on a Primary Medical Services (PMS) contract agreement for general practice.

The practice has one male GP, one nurse practitioner, one healthcare assistant, a practice manager, a deputy manager and three medical receptionists.

Information taken from Public Health England placed the area in which the practice was located in the third more deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The practice's age distribution profile is weighted towards a slightly younger population than national averages. There are more patients registered with the practice between the ages of 0-18 years than the national averages.

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

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

• Is it safe?

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• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

• Older people

• People with long-term conditions

• Families, children and young people

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

• People whose circumstances may make them vulnerable

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

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

We carried out an announced inspection on 23 June 2015. We visited the practice's surgery in South Shields. We spoke with seven patients in total and a range of staff from the practice. We spoke with the practice manager, the GP, the nurse practitioner and the reception staff on duty. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed nine CQC comment cards where patients from the practice had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Requires improvement

Are services safe?

Our findings

Safe Track Record

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

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

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. The practice manager showed us a 'log book' they had introduced some time ago where staff could record incidents or events, including near misses. We saw this had been completed on a regular basis when it was first introduced; however the use of the book had reduced over time. This could mean some opportunities to learn from events and near misses to improve patient safety were missed.

Staff we spoke with were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said that everybody had a responsibility to report and record matters of safety. We saw that records were kept of significant events and incidents. We reviewed a sample of the reports completed by practice staff during the previous year, and the minutes of meetings where these were discussed. The records we looked at showed the practice had managed these consistently over time and so could demonstrate a safe track record.

Learning and improvement from safety incidents

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

We saw the practices own incident forms were available to staff in hard copies. Once completed these were sent to the practice manager who managed and monitored them. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken.

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

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records we reviewed showed that staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults

and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out-of-hours. We saw contact details were easily accessible to staff throughout the practice.

The practice's lead GP was the designated lead in the safeguarding of vulnerable adults and children. Staff we spoke with were aware of who the lead for the practice was and who to speak with if they had any safeguarding concerns.

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

A chaperone policy was in place and a notice was displayed on the outside of the GPs consulting room door to inform patients of their right to request a chaperone. The notice was visible to patients who were seated within the practice's small waiting area. The practice manager said chaperoning was carried out by the nurse practitioner and healthcare assistant who had been trained to fulfil this role. A small number of interpreters the practice used on a regular basis had also chaperoned for some patients whose first language was not English. All of the staff that carried out chaperone duties had been checked via the Disclosure and Barring Service (DBS).

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated information held about the patient, including scanned copies of communications from hospitals. Staff had completed Caldicott training and were aware of confidentiality and data protection policies.

Medicines Management

We checked medicines stored in the treatment room and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a process in place for ensuring that medicines were kept at the required temperatures. Records showed fridge temperature checks were carried out by the nurse practitioner on the fridge in their room, which ensured the medication kept there was stored at the appropriate temperature. The GP had a refrigerator in their consulting room which contained a small number of injectable medicines; however there were no records kept to show the temperature of the fridge had been monitored. We also found some food and drink stored in this refrigerator as well as medicines. The absence of temperature monitoring records and the presence of food and drink in the GPs refrigerator both presented a risk to the safety of the medicines stored in their refrigerator. The practice assured us the injectable medicines would be disposed of and replaced and food and drink would no longer be stored in the same refrigerator as medicines in the future.

Processes were in place to check medicines were within their expiry date and suitable for use. Most of the medicines we checked were within their expiry dates; however a small number had passed their expiry date. This included a GTN spray (used to treat chest pain) in the nurse's cupboard and some needles in the anaphylaxis treatment box. These were removed and were to be replaced by the practice.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were not always handled in accordance with national guidance. They were stored in a locked cupboard and comprehensive records were kept of loose-leaf prescriptions as they were used. However records were not kept of the first and last serial numbers of boxes of loose-leaf blank prescriptions on receipt into the practice. This presented a risk, as the practice would not be able to identify or report the serial numbers of any prescription forms that were misdirected or lost. Prescription pads available to be used by the GP on home visits were also kept in a locked cupboard, however records of the serial numbers on these prescription forms were not kept. In addition, the GP kept some prescriptions used specifically for the prescribing of some medicines in their consulting room. These arrangements were not secure.

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

The nurse practitioner used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The health care assistant administered flu vaccines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence

that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

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

Cleanliness & Infection Control

We saw the practice was clean, tidy and well maintained. The practice was based in a purpose built health centre shared with three other GP practices and other healthcare professionals. The cleaning of the building was completed by NHS Property Services. There were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness.

The nurse practitioner was the designated lead for infection control. Staff were able to describe the precautions they took on a daily basis with regards to infection control; for example on the receipt of specimens from patients. Clinical staff had received training about infection control specific to their role and non-clinical staff had received some in-house training. The nurse practitioner said they provided practical hand washing technique training for all the practice staff annually; the most recent session was held in April 2015.

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

The clinical rooms we checked contained personal protective equipment such as latex gloves and there were privacy curtains and paper covers for the consultation couches. Arrangements were in place to ensure the curtains were regularly cleaned and replaced. Where sharps bins (used to dispose of needles and blades safely) were contained within consultation rooms, these where appropriately labelled, dated and initialled. We found one recently constructed sharps bin had not been dated and initialled on construction. The treatment rooms contained hand washing sinks, antibacterial gel and hand towel dispensers to enable clinicians to follow good hand hygiene practice. Hand hygiene techniques signage was displayed throughout the practice. Spillage kits were available to deal with any biological fluid spills.

An 'Infection Control Inspection Checklist' audit had been completed by the practice in February 2015. The nurse practitioner said the infection control audit results were generally good and the most recently completed audit reflected this. They said the main issue identified tended to be the carpets in the small practice reception area and this was regularly reported to NHS Property Services by the practice manager.

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

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. The most recent testing had covered some but not all of the practice's portable electrical equipment. The practice manager was making arrangements for the remaining equipment to be tested shortly. We saw evidence of calibration of relevant equipment; for example, weighing scales and blood pressure monitoring equipment. The practice maintained records showing when the next service was due.

Staffing & Recruitment

The practice had a recruitment policy that set out the standards they followed when recruiting staff. Records we looked at included evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with an appropriate professional body and criminal record checks via the Disclosure and Barring Service (DBS). We looked at the staff file for the member of

staff most recently recruited. Their file contained copies of all of the information required, including their job application form, DBS check and documents to confirm their identity.

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

We asked the practice manager how they assured themselves that the GP and nurse practitioner 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 the GP and nurse routinely provided them with evidence of their professional registrations and we saw copies of these records were kept. The GP had medical indemnity insurance in place and we saw certificates to confirm this.

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for the reception and support staff to ensure there was enough staff on duty. There were arrangements in place for members of staff to cover each other's annual leave. The practice did not use locum GPs to cover for the GPs holidays. The GP told us they did not take much time off and when they did, the nurse practitioner provided cover. Informal arrangements were in place with neighbouring GP practices within the same building if access to a GP was required at these times.

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

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building and environment by NHS Property Services, 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.

Identified risks had been recorded and each risk was assessed with mitigating actions noted to manage the risk. Health and safety risk assessments had been completed; however these required updating. For example, we saw a risk assessment of the office area had been completed in October 2012. Risk assessments had also been completed for slips and trips, manual handling and working at height. The practice manager had contacted an external agency to come into the practice to help to bring these up to date.

We saw a fire safety management plan was in place and the responsibility for the fire risk assessment lay with NHS Property Services. The fire alarms within the building were tested every Thursday. A full fire drill had been completed on 5 June 2015. The practice manager was the nominated fire warden for the practice.

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

Arrangements to deal with emergencies and major incidents

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

Emergency medicines were available in a secure area of the practice and all the staff we spoke with knew of their location. Medicines included those for the treatment of cardiac arrest, breathing difficulties and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use; however a small number had passed their expiry date.

Requires improvement

Are services safe?

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, loss of access to the building, loss of IT systems and severe weather. It also included a detailed list of contact details. The plan had been updated in June 2015. The practice manager kept a copy of the plan at home. This ensured they had the information they needed to report any problems if they discovered anything that would impact on the operation of the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The GP and nurse practitioner led together on clinical matters, including in specialist clinical areas such as care of the elderly and patients with long term conditions. They had joint overall responsibility for ensuring the disease or condition was managed effectively in line with best practice. They both took responsibility for ensuring the day-to-day management of a disease or condition was in line with practice protocols and guidance. They said they would not hesitate to ask for or provide each other with advice and support. Staff had access to the necessary equipment and were skilled in its use; for example, blood pressure monitoring equipment.

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

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

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

Management, monitoring and improving outcomes for people

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

The GP was able to show us some clinical audits that had been completed. We looked at some examples of clinical audits that had been undertaken in the last few years. The audits were generally quite small in terms of the amount of patient data reviewed. For example, an audit on antibiotic prescribing involved one prescription for the first cycle and one prescription for the second cycle. In addition, not all of the audits we reviewed had been through two full cycles, so therefore could not demonstrate improvements in outcomes for patients. The practice should aim to demonstrate an on-going audit programme where they have made continuous improvements to patient care in a range of clinical areas as a result of clinical audit.

We saw a series of five 'Diabetes Care In Practice' reports had been produced in partnership with the local clinical commissioning group (CCG) over a two year period. These had led to some improvements in the recording of blood pressures for patients living with diabetes.

The practice used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. The Quality and Outcomes Framework is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions (e.g. diabetes) and implementing preventative measures. The results are published annually. This practice was not an outlier for any QOF (or other national) clinical targets. It achieved 94.5% of the total QOF points available to the practice in 2013/2014, which was just above the national average of 94%. Some examples to demonstrate this included:

- Performance for depression related indicators was better than the national average (87.7% compared to the national average of 86.3%).
- Performance for asthma related indicators was better than the national average (100% compared to the national average of 97.2%).

Good

Are services effective?

(for example, treatment is effective)

- Performance for chronic obstructive pulmonary disease (COPD) related indicators was lower than the national average (94.3% compared to the national average of 95.2%).

The QOF allows practices to exception-report (exclude) specific patients from data collected to calculate achievement scores. Patients can be exception-reported from individual indicators for various reasons. For example if they are newly diagnosed or newly registered with a practice, if they do not attend appointments or where the treatment is judged to be inappropriate by the GP (such as medication cannot be prescribed due to side-effects). The practice had a robust system in place to validate the use of exception reporting. Any patient identified as being eligible to be exception reported was recorded on a form that was passed to the practice manager. They then reviewed the information provided alongside the patients' records before validating or rejecting the request to exception report. The practice had a very low exception rate of 3.3%, which was well below the local average of 9.1% and the national average of 7.9%. This reflected the robust system they had in place.

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

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as cardiopulmonary resuscitation (CPR) and safeguarding. All GPs were up to date with their yearly continuing professional development requirements and had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Staff received annual appraisals which identified learning needs from which action plans were documented. The nurse practitioner was appraised by the GP, the practice manager and nurse practitioner appraised the healthcare assistant and the practice manager appraised the administrative and support staff. The practice manager said they had not been appraised for two to three years. We saw records in staff files of appraisals completed within the last 12 months. Staff we spoke with confirmed the practice was supportive in providing training and funding for relevant courses.

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 had completed a wide range of training and development. This included training on independent prescribing, cervical screening, immunisations, wound infection control and heart failure management in primary care.

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

Working with colleagues and other services

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

Good

Are services effective?

(for example, treatment is effective)

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

The practice's GP and nurse practitioner attended these meetings and felt this system worked well. They remarked on the usefulness of the meetings as a means of sharing important information. A 'traffic light system' was used to indicate those patients that required more intense input from the clinical team. The practice also held regular meetings with midwives and health visitors to discuss the care of children and patients identified as being at risk.

The practice was linked with a local care home and the GP visited the home at least once per week. The care home had been advised of a dedicated telephone number for the practice so they could speak with the GP quickly if they were concerned about a patient.

Information Sharing

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

Hospital discharge summaries were checked by the GPs, who added or updated any changes to medications for patients. The summaries were then passed to the administrative staff for coding and any other actions that were required. Results of blood tests completed outside the practice for patients were reviewed by the nurse practitioner.

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

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. They also demonstrated an understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). We saw records to confirm training on the Mental Capacity Act had been completed.

There was a practice policy for recording consent for specific interventions. For example, verbal consent was taken from patients for routine examinations and verbal and implied consent for the measurement of blood pressure. Written consent was obtained before any minor surgical procedures were completed.

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

Health Promotion & Prevention

The practice identified people who needed on-going support and were proactive in offering this. This included those receiving end of life care and those at risk of developing a long term condition. For example, there was a register of all patients diagnosed as living with dementia. Nationally reported QOF data (2013/14) showed that the practice had obtained 100% of the points available to them for providing recommended clinical care and treatment to these patients. The data indicated that 100% of patients on the register had a face-to-face annual review in the preceding 12 months. This was 13.8% above the local CCG average and 16.2% above the England average.

The practice held a weekly baby clinic and arranged antenatal checks, baby checks, childhood immunisations and mothers' post-natal checks on the same day. A

Good

Are services effective?

(for example, treatment is effective)

designated member of staff co-ordinated the clinic and all patient appointments. This helped to reduce the need for mothers, babies and young children to attend on more than one occasion. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance (2013/14) for immunisations was generally in line with or slightly higher than the averages for the local CCG. For example, and Men C vaccination rates for one year old children were 96.7% compared to 84.8% across the CCG and Men C Booster vaccination rates for two year old children were 100% compared to 98.2% across the CCG.

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

Processes were also in place to ensure the regular screening of patients was completed, for example, cervical screening. Performance in this area for 2013/14 was slightly below the national average at 75.2% (the national average was 81.9%).

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. There was a range of information on display within the main health centre waiting area and the practice's own small patient waiting area. This included a number of health promotion and prevention leaflets, for example on mental health, counselling services and lifestyle advice. The practice's website included links to a range of patient information, including for child health, first aid, sexual health and dietary advice.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with said they were treated with respect and dignity by the practice staff. Comments left by patients on Care Quality Commission (CQC) comment cards reflected this. Of the nine CQC comment cards completed, six patients made direct reference to the caring and respectful manner of the practice staff. Words used to describe the staff and their approach to patients included kind, friendly, helpful, nice people, wonderful, caring, polite and understanding.

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

The practices own small reception area was separate from the main health centre patient waiting area, with no direct line of sight between the two. The practice had recognised confidentiality could be an issue when patients attended the surgery. This was due to the layout of the building and the very small working area the practice had been allocated. The practice were managing this as well as they could by asking patients to take a seat in the main health centre waiting area before calling them through for their appointment. We saw staff who worked in the practices small reception area made every effort to maintain patients' privacy and confidentiality. Voices were lowered and personal information was only discussed when absolutely necessary. Phone calls from patients and other healthcare professionals were taken by administrative staff in an area where confidentiality could be maintained.

Patients' privacy and right to confidentiality were maintained. For example, the practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination. Staff we spoke with said a spare room or more private area was made available for patients to use if they wanted to speak about matters in private. This reduced the risk of personal conversations being overheard.

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

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

The practice had policies in place to ensure patients and other people were protected from disrespectful, discriminatory or abusive behaviour. The staff we spoke with were able to describe how they put this into practice. This included being aware of the diverse ethnic community within South Shields and respecting their individual cultures. The practice's patient list included a significant number of patients from within the local Bangladeshi community. The practice had recognised and embraced this and a number of patient information leaflets were available for patients in this language.

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey information we reviewed (published in January 2015) showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, and rated the practice well in these areas. The results from patients on their experiences at their last nurse appointment were more positive than from patients on their experiences at their last GP appointment. For example, the survey showed:

- 74% of practice respondents said the last GP they saw or spoke to involved them in decisions about their care (local clinical commissioning group (CCG) average 80%; national average 75%.
- 79% said the last nurse they saw or spoke to involved them in decisions about their care (local CCG average 72%; national average 66%).

In general, the National GP Patient Survey results for the practice were well above the local and national averages for nurse-related questions and lower than local and

national averages for GP-related questions. The practice manager had not looked at these results or the reasons behind them when we asked them about this. For example, the survey showed:

- 80% of respondents said the last GP they saw or spoke to was good at listening to them (local CCG average 92%; national average 87%).
- 93% of respondents said the last nurse they saw or spoke to was good at listening to them (local CCG average 82%; national average 79%).
- 77% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments to them (local CCG average 87%; national average 82%).
- 87% of respondents said the last nurse they saw or spoke to was good at explaining tests and treatments to them (local CCG average 81%; national average 77%).

Feedback from patients we spoke with was generally positive. We spoke with six patients on the day of the inspection; four of whom were entirely happy with the way they were dealt with by the staff. They told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also said they felt listened to and supported by staff and felt they had sufficient time during consultations to make informed decisions about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and supported these views.

Two of the patients we spoke with were not as happy with their consultations and the comments they made reflected some of the findings from the National GP Patient Survey. One patient felt the GP should listen more to them and they felt they did not get proper answers to their questions. Another patient felt they had not been informed about an abnormal test result. We passed this information on to the GP, nurse practitioner and practice manager who said they would take this feedback on board.

The practice had identified its most at risk and vulnerable patients. They had signed up to the enhanced service for 'Avoiding Unplanned Hospital Admissions' and were completing the work associated with this service. Enhanced Services are services which require an enhanced level of service provision beyond their contractual obligations, for which they receive additional payments. A total of 61 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 for 44 patients initially. The GP and nurse practitioner described some examples of care plans agreed with a number of at risk patients.

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

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice and rated it well in this area. The CQC comment cards we received were also consistent with this feedback. For example, patients made comments such as the doctors were always there to listen and staff were very supportive too.

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

The GP visited patients who were approaching the end of their life and were identified as being in receipt of palliative care. This was in order to ensure as far as possible, patients preferred place of death could be met. The practice had participated in the 'Better Outcomes Scheme' run by the local CCG and were able to demonstrate improvements in the recording of patients preferred place of death. They had identified 17 patients approaching end of life in September 2014 and at that time, only five had their preferred place of death recorded. By April 2015, this had improved to 14 of the 17 patients originally identified.

Support was provided to patients during times of need, such as in the event of bereavement. Staff we spoke with in the practice recognised the importance of being sensitive to patients' wishes at these times. The GP would send out condolence letters to bereaved relatives to offer support and guidance.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

Where patients were known to have additional needs, such as having caring responsibilities or 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.

The practice engaged with the clinical commissioning group (CCG) to discuss local needs and service improvements that needed to be prioritised. They also used the practice's electronic patient records system to assess and analyse the needs of their practice population. For example, they used it to identify patients for inclusion on their chronic disease registers.

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Patients could access appointments face-to-face in the practice, receive a telephone consultation with the GP or nurse practitioner, or be visited at home. Longer appointments were available for people who needed them and also on request.

The practice held regular internal as well as multidisciplinary meetings to discuss patients and their families' care and support needs. The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment.

The practice did not have an active patient participation group (PPG) at the time of our inspection. They used to have a group; however they had been unsuccessful in recruiting to this to replace members who had left. The practice manager explained they had recently relied on speaking with patients opportunistically when they came into the practice as a means of capturing their views. We spoke with a patient who had been consulted with in this way, ahead of the inspection. They said the practice were actively looking to re-launch the patient group and had gathered the details of a number of patients who were interested in forming it. The practice manager showed us they had the details of five patients who had shown an interest. The patient we spoke with said they had been asked about a number of things recently, including arrangements for ordering prescriptions, the telephone triage service the practice offered and the practice's opening times. The practice was promoting the group within the surgery, on their website and by attaching letters to patients repeat prescription requests.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, opening times had been extended to provide pre-bookable early evening appointments with the GP one day per week. The nurse practitioner also ran a session later in the day once a week. This helped to improve access for those patients who worked full time.

The majority of the practice population were English speaking patients; however the practice had a significant number of patients registered from within the local Bangladeshi community. Access to translation services was available if they were needed. The practice maintained registers for patients with caring responsibilities, patients with learning disabilities and patients receiving palliative care. All of these measures helped to ensure that all of their patients had equal opportunities to access the care, treatment and support they needed.

The premises and services had been adapted as far as possible to meet the needs of people with disabilities. The surgery was located on the ground floor and all services were provided from this level. The main entrance door to the health centre was automated and the treatment and consulting rooms could be accessed by those with mobility difficulties. The practices own reception desk counter had a hatch which could be lowered to enable patients who used wheelchairs to speak face to face with the reception staff. We saw that the main health centre waiting area was large enough to accommodate patients with wheelchairs and prams. 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 next to the health centre.

The practice was a single handed GP practice with a male GP. Patients were made aware of this on registering with

Good

Are services responsive to people's needs?

(for example, to feedback?)

the practice, however there were no formal arrangements in place for patients to be able to see a female GP if they wanted to. The practice did have a female nurse practitioner who was able to provide the majority of services offered by a GP.

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

Access to the service

The patients we spoke with and those who filled out Care Quality Commission (CQC) comment cards said they were satisfied with the appointment systems operated by the practice. Comments included; waited only five minutes – straight in to see doctor and can generally get an appointment with the doctor the next day. None of the nine patients who filled in CQC comment cards said they had any problems or concerns with access to the service. All of the patients we spoke with said they had been able to see a GP the same day if their need had been urgent.

The latest results from the National GP Patient Survey published in January 2015 were mostly positive in terms of patient feedback regarding appointments. 84% of respondents said they were able to get an appointment to see or speak to someone the last time they tried. This was higher than the local CCG average of 76% and just below the national average of 85%. The practice achieved positive results from patients on their experience of making an appointment and the convenience of their last appointment. 86% of respondents said their experience of making an appointment was good (compared to the CCG average of 79%) and 98% said their last appointment was convenient (compared to the CCG average of 93%). Both of these results were higher than the national averages of 74% and 92% respectively.

We looked at the practice's appointments system in real-time on the afternoon of the inspection. Routine appointments to see the GP and nurse practitioner were available later the same day and also on the day after the inspection. Appointments to see the healthcare assistant were available to be booked in two days' time, which was their next working day. Urgent same-day appointments were released for patients to book each day. The practice offered telephone consultations with the GP and nurse practitioner too and these were available to be booked on the day. The nurse practitioner ran walk in clinics three times a day, as well as offering telephone triage; early mornings, at midday and early in the evenings. This helped to improve same day access to the service for the practice's patients.

The practice was open from 8.00am to 6.00pm Monday to Friday. In addition, an early evening surgery with pre-bookable GP appointments was held one day per week. The nurse practitioner also ran a session later in the day once a week. The practice's extended opening hours one evening per week were particularly useful to patients with work commitments. This was confirmed by patients we spoke with who normally worked during the week.

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

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

Listening and learning from concerns & complaints

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

We saw the practice had received seven formal complaints in the last 12 months and these had been investigated in line with their 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

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

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice's aims and objectives were to provide good quality primary care services from within a clean, suitably equipped and safe environment. This was reflected in the practice's statement of purpose. It also referred to making efficient use of NHS resources, treating all patients with dignity and respect and liaising with other agencies and NHS colleagues in an effective manner in the best interests of the patient.

We spoke with a variety of practice staff including the practice manager, the GP, 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. Staff regularly spoke of working towards the same aims – to provide a good service in a caring environment and to continue to try and improve.

The practice did not have a formal strategy or business plan in place. Succession planning had been discussed informally, but the practice manager said it had not progressed beyond that. The GP and practice manager both said they were aware of the need to formalise these discussions and to plan for the future of the practice.

Governance Arrangements

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

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

The practice had completed a number of clinical audits and reviews or first cycles of clinical audits which it used to monitor quality and systems to identify where action should be taken. The number of patients identified within the audit samples was relatively small.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and actions to mitigate these risks had been put into place. Health and safety risk assessments had been completed; however these required updating. The practice manager had contacted an external agency to come into the practice to help to bring these up to date. Risk assessments had also been completed for slips and trips, manual handling and working at height.

The practice held regular meetings for staff. These included monthly primary care meetings that were attended by most of the staff in the practice; clinical and non-clinical. Occasional meetings of the administrative team were also held, the most recent of which took place in February 2015. We looked at minutes from some of these meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, the practice manager was the lead for non-clinical matters, the nurse practitioner had the lead role for infection control and the GP was the lead for safeguarding and on clinical matters. We spoke with a range of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice manager was responsible for the application of the provider's human resource policies and procedures. We reviewed a number of policies, for example on the recruitment of staff, chaperoning and infection control, which were in place to support staff. We saw policies were available for all staff to access. Staff we spoke with knew where to find the practice's policies if required.

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

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

that whole staff meetings were held. Staff told us they had the opportunity and were happy to raise issues at meetings. They said this process worked well for them and encouraged them to contribute to discussions about how the practice was run.

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

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

The staff we spoke with, including the practice manager and GP told us forward planning was discussed informally; however formal plans were not in place to develop and improve the services provided.

The practice did not have a patient participation group (PPG) at the time of the inspection. They used to have a group; however they had been unsuccessful in recruiting to this to replace members who had left. The practice manager explained they had recently relied on speaking with patients opportunistically when they came into the practice as a means of capturing their views. A patient we spoke with said they had been asked about a number of things recently, including arrangements for ordering prescriptions, the telephone triage service the practice offered and the practice's opening times. The practice manager showed us they had the details of five patients who had shown an interest in forming a group. The practice was promoting the group within the surgery, on their website and by attaching letters to patients repeat prescription requests.

In 2015 the practice had carried out a local survey of their patients opportunistically when they came in to the practice. The practice manager showed us the analysis of the survey, which captured the views of 94 patients in total. Patients had been asked about access to appointments, access within 48 hours, the ability to speak with clinicians on the telephone and the practice's triage system. Patients were largely satisfied with the service, with the actions agreed based around maintaining levels of access and patients' satisfaction with these. The results and actions agreed were available on the practice noticeboard and website.

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

Management lead through learning & improvement

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

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

The practice manager met with other practice managers in the area and shared learning and experiences from these meetings with colleagues. They also said they felt very well supported by the GP and the staff team in general.

The GP met with colleagues at locality and clinical commissioning group (CCG) meetings. They attended learning events and shared information from these with the others in the practice.

The nurse practitioner had been supported to and completed a significant number of qualifications as part of their clinical development. This included a foundation level sexual health course, followed by the integrated sexual health pathway to degree level. As a result of this, the

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practice was able to provide a full level two sexual health service. This was particularly relevant to the practice, as their patient list showed they had a young demographic population.

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not provided in a safe way for service users because some aspects of the management of medicines were unsafe. Specifically, some temperature sensitive medicines were being kept in a refrigerator whose temperature was not being monitored, along with some food and drink. A small number of medicines held were beyond their expiry date. Blank prescription forms were not always handled in accordance with national guidance. This included some prescriptions used specifically for the prescribing of certain medicines. The arrangements for the storage of these forms were not secure. (Regulation 12(1)(2)(g))