Dr Simpson and Partners

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Simpson and Partners on 9 June 2015. Overall, the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Information about safety was appropriately recorded and reviewed;
- Risks to patients were assessed and well managed;
- The practice was clean, hygienic and good infection control arrangements were in place;
- Patients' needs were assessed and care was planned and delivered following best practice guidance;
- The practice had scored well on clinical indicators within the Quality and Outcomes Framework. They achieved 93.2% for the year 2013/14, which was 0.9 percentage points below the CCG Average and 0.9 above the England Average.
- Patients said they were treated with compassion, dignity and respect and that they were involved in decisions about their care and treatment;
- Information about the services provided and how to raise any concerns or complaints, was accessible and easy to understand;
- Patients said they found it easy to make an appointment and urgent same-day access was available;
- The practice had good facilities and was well equipped to treat patients and meet their needs;
- There was a clear leadership structure and staff felt supported by the management team. The practice actively sought feedback from patients;
- We found there was good staff morale and a learning culture in the practice.

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

The provider should:

- Ensure that the serial numbers of blank prescriptions are recorded in accordance with national guidance to reduce the risk of theft or misuse.

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- Ensure there are warning signs to highlight the dangers presented by the storage of oxygen within the practice and to alert the emergency services, such as the fire brigade, in the event of a fire.
- Undertake the recommended actions identified in the risk assessment, to protect against the risk of legionella.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Evidence showed the practice had managed safety incidents and information consistently over time and could demonstrate a safe track record over the long-term. The practice was open and transparent when there were near misses or when things went wrong. Lessons were learned and communicated widely to support improvement. The practice had regular weekly multidisciplinary meetings to discuss the safeguarding of vulnerable patients. Medicines were managed safely within the practice. Information about safety was recorded, monitored, appropriately reviewed and addressed. The practice was clean and effective arrangements were in place to reduce the risk of infections. Risks to patients were assessed and well managed. There was an oxygen cylinder available to both practices in the building, which we saw was regularly serviced. However, there were no warning signs to highlight the dangers presented by the storage of oxygen within the practice and to alert the emergency services, such as the fire brigade, in the event of a fire. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Nationally reported data showed that the practice was performing in line with local Clinical Commissioning Group (CCG) and England averages. We found the practice was supporting people to live healthier lives through health promotion and prevention of ill health. There was good evidence of how the practice worked with other healthcare professionals, and involved patients in decisions about their care, to improve health outcomes.

Are services caring?

Good

The practice is rated as good for providing caring services. Nationally reported data showed that patients rated the practice higher than other practices for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were

Summary of findings

involved in decisions about their care and treatment. 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 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 NHS England Area Team and 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 named GP and that there was continuity of care, with urgent appointments available the same day. 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 and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. They had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. 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. 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 that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in their population and provided a range of enhanced services, for example, in dementia and end-of-life care. Staff were responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing 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. These patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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, for example, children and young people who had a high number of A&E attendances. Immunisation rates were in line with local averages for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Cervical screening rates for women aged 25-64 were slightly below the national average at 76.6%, compared to 81.9%. The practice planned to improve this rate by taking over management of the invite and appointment process themselves.

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 they

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offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

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 who misuse substances and those with a learning disability. They carried out annual health checks for people with a learning disability. They offered longer appointments for those who required them.

They had told vulnerable patients about 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.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people with poor mental health (including patients with dementia). The practice held a register of patients experiencing poor mental health and there was evidence they carried out annual health checks for these patients. The practice regularly worked with the multi-disciplinary teams in case management of people experiencing poor mental health, including those with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. They had systems in place to follow up patients who had attended Accident and Emergency (A&E).

Summary of findings

What people who use the service say

We spoke with seven patients during the inspection. This included two patients from the practice Patient Participation Group (PPG).

Patients told us staff were friendly and always helpful. They told us staff treated them with dignity and respect. Also, when they saw clinical staff, they felt they had enough time to discuss the reason for their visit and staff explained things to them clearly in a way they could understand. All the patients we spoke with said they could get an appointment easily, and this was always quickly if there was an urgent need. Some of the patients we spoke with told us they got an appointment time on the same day they contacted the practice to request one. Patients were generally happy with the appointments system.

All the patients we spoke with told us they would recommend the practice to family and friends.

We reviewed six CQC comment cards completed by patients prior to the inspection. All of these commented positively on the practice, staff and the care and treatment offered. In particular, patients commented staff were helpful and listened to them. Also, that it was easy to get appointments at the practice. Words used to describe the practice included exemplary, 100% and friendly.

Findings from the 2014 National GP Patient Survey, published in January 2015 for the practice, indicated most patients had a good level of satisfaction with the care and treatment they received. The results were generally in line with or better than other GP practices within the local Clinical Commissioning Group (CCG) area and nationally. For example, the majority of patients rated the practice as good or very good (at 95.9%), this was higher than the local Clinical Commissioning Group (CCG) average (at 90.6%) and England average (at 85.2%).

The three responses to questions where the practice performed the best when compared to other local practices were:

- 77% of respondents with a preferred GP usually got to see or speak to that GP (compared to local CCG average of 61%);
- 96% of respondents described their experience of making an appointment as good (compared to local CCG average of 80%);
- 94% of respondents found it easy to get through to this surgery by phone (compared to local CCG average of 82%).

The two responses to questions where the practice performed least well when compared to other local practices were:

- 87% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments (compared to local CCG average of 90%);
- 89% of respondents said the last GP they saw or spoke to was good at treating them with care and concern (compared to local CCG average of 90%);

These were in line with national and local CCG averages.

These results were based on 115 surveys that were returned from a total of 281 sent out; a response rate of 41%.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that the serial numbers of blank prescriptions are recorded in accordance with national guidance to reduce the risk of theft or misuse.
- Ensure there are warning signs to highlight the dangers presented by the storage of oxygen within the practice and to alert the emergency services, such as the fire brigade, in the event of a fire.
- Undertake the recommended actions identified in the risk assessment, to protect against the risk of legionella.

Dr Simpson and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector, and included a specialist adviser who was a GP.

Background to Dr Simpson and Partners

Dr Simpson and Partners is located in the Boldon Colliery area of South Tyneside. The practice provides services to around 7700 patients and provides services from the following address, which we visited during this inspection:

- Colliery Court Medical Group, The Medical Centre, Gibson Court, Boldon Colliery, Tyne and Wear, NE35 9AN.

The practice is co-located with another GP practice in the same building. Dr Simpson and partners is to the right hand side of the building. The building is on two levels, with all patient services provided on the ground floor. The premises are purpose built and provide fully accessible treatment and consultation rooms for patients with mobility needs. Ramps are in place both at the front door and within the car park. Car park bays are provided close to the building, with some reserved for patients with disabilities. There is a disabled toilet situated off the waiting room, as well as toilets for all patients to use.

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

The practice has four GP partners. There is also one salaried GP; one GP Registrar (fully-qualified doctors who spend time working in a practice to develop their skills in general practice); two practice nurses; one healthcare assistant and a team of administrative support staff. There are both male and female clinical staff at the practice, with three female and three male doctors.

Surgery opening times are Monday to Friday 8:30am to 6:00pm, with late opening on alternate Tuesdays and Wednesdays from 8:30am to 8:00pm.

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

The practice serve an area with lower levels of deprivation affecting children and people aged 65 and over, when compared to other practices in the local CCG, and the England average. The practice's population includes more patients aged under 18 years and aged 65 and over, than other practices in the local CCG area.

The average male life expectancy is 77 years and the average female life expectancy is 81. Both of these are two years lower than the England average. The number of patients reporting with a long-standing health condition is higher than the national average (practice population 56.1% compared to a national average of 54.0%). The number of patients with health-related problems in daily life is slightly higher than the national average (49.5% compared to 48.8% nationally). There are a higher number of patients with caring responsibilities at 24.27% compared to 18.2% nationally.

Why we carried out this inspection

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

Detailed findings

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

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)

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. This did not highlight any indicators for us to follow up as part of the inspection, across the five key question areas. 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 9 June 2015. We spoke with seven patients and 10 members of staff. We interviewed two GPs, one GP registrar (fully-qualified doctors who spend time working in a practice to develop their skills in general practice); the practice manager and assistant practice manager; the pharmacist; a practice nurse and three staff carrying out reception and administrative duties. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed six 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. We spoke with managers of two local care homes, where the practice provided services to some of the residents.

Good

Are services safe?

Our findings

Safe track record

When we first registered this practice in April 2013, the practice declared they were fully compliant with the regulations at that time. We reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice. There were no notifications of safeguarding or whistleblowing concerns made to CQC.

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed Care Quality Commission (CQC) comment cards reflected this.

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, they considered reported incidents, national patient safety alerts as well as comments and complaints received from patients.

Staff we spoke with were aware of their responsibilities 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. For example, a medication error was identified where a different medicine with a similar spelling was prescribed. Although no harm had been caused to the patient, the practice considered this through the significant event process and discussed it at a clinical meeting to identify ways to prevent the prescribing error happening again. This included the GP typing the full spelling of the medicine to ensure staff selected the right one.

The practice used the CCG-wide Safeguard Incident Reporting Management System (SIRMS) to record incidents and provide feedback on patients' experiences of care within other services in the local area.

We reviewed safety records and incident reports for the last 12 months. This showed the practice had managed these consistently over time and could show evidence of a safe track record over the long-term.

Learning and improvement from safety incidents

The practice was open and transparent when there were near misses or when things went wrong. The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to view these. Significant events were a standing item on weekly multi-disciplinary meetings. We saw evidence that significant events were also discussed at dedicated 'time-in' meetings and sessions to review actions from past significant events and complaints. We saw notes of these meetings over the last year which confirmed this. There was evidence the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration as a significant event or incident and they felt encouraged to do so. Staff told us they felt confident in raising issues to be considered at the meetings and felt action would be taken. A culture of openness operated throughout the practice, which encouraged errors and 'near misses' to be reported.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We saw there were 13 significant events recorded over the last year. Records were completed in a comprehensive and timely manner.

We saw evidence of action taken as a result of significant events. For example, a patient had complained they were embarrassed that a patient information leaflet had been attached to their prescription. They felt this highlighted a personal problem to staff working within the practice. The practice apologised to the patient. They adopted approaches to minimise patient embarrassment by, for example, putting information leaflets in envelopes before attaching them to a prescription.

National patient safety alerts were disseminated by email to practice staff. The practice manager kept a paper record of these and noted what action had been taken by the practice as a result of the alerts. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were added to the practice meeting agenda, where appropriate, to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Good

Are services safe?

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received role specific training on safeguarding. We saw evidence that GPs had received training for safeguarding children to Level 3. 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 and knew how to share information, record safeguarding concerns and contact the relevant agencies in working hours and out-of-normal hours. Contact details were easily accessible on the practice intranet.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to within the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example, with regards to children who were the subject of child protection plans or 'looked after' children.

Parents who did not engage with the practice regarding health care of their children were followed up. For example, the practice had systems to monitor babies and children who failed to attend for health checks or childhood immunisations. Also, children with high levels of attendance at A&E were monitored to identify any concerns about their safety. These were brought to the GPs attention, who then worked with other health and social care professionals to ensure children were safe and their needs were being met.

There was a chaperone policy, which was available on the staff intranet page. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff told us this was advertised on the information screen in the waiting area. The practice manager told us clinical staff, such as practice nurses and the health care assistant, acted as chaperones. Previously reception staff had been trained to provide a chaperone service. But the practice manager had ceased to use these staff as it was some time since they had undertaken training. Staff who provided a chaperone service had also received Disclosure and Barring Service (DBS) checks.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

Medicines management

Arrangements were in place to regularly monitor the GPs' prescribing practice. A pharmacist attended the practice. The pharmacist and GPs we spoke with told us the pharmacist carried out various audits, which we saw evidence of, to make sure medicines were being used effectively. They also provided the practice with advice and support. Practice staff told us the local CCG provided leadership for the area in relation to audit programmes and monitoring of prescribing patterns.

We checked vaccines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a process for checking medicines were kept at the required temperatures and this was being followed by the practice staff. This ensured the medicines in the refrigerator were safe to use. In November 2014 the practice had identified that a refrigerator had operated outside of the recommended temperature range. Staff had taken immediate and appropriate action to safeguard temperature sensitive medicines. A service visit was arranged and this identified an incorrect reading was given due to a faulty temperature monitor gauge. As a result the practice purchased a separate clinical thermometer to provide an independent check on temperatures within the refrigerator. We saw this was in place within the refrigerator.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. This included the supply of emergency medicines kept by the practice. Expired and unwanted medicines were disposed of in line with waste regulations.

Good

Are services safe?

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that nurses had received appropriate training to administer vaccines.

A process was in place to handle medicines safety alerts. The practice manager cascaded this information and noted what action the practice had taken as a result.

Patients were able to order repeat prescriptions using a variety of ways such as by telephone, online and by post. The practice website provided patients with helpful advice about ordering repeat prescriptions. Staff knew the processes they needed to follow in relation to the authorisation and review of repeat prescriptions. We observed reception staff dealing effectively with requests for repeat prescriptions.

A system was in place which helped to ensure patients who were receiving prescribed medicines were regularly reviewed. The GP we spoke with told us these reviews were carried out at least annually. All prescriptions were reviewed and signed by a GP before they were given to the patient.

Blank prescriptions were stored in a secure area in a locked cupboard. However, there was no process in place to record and monitor the stock of blank prescriptions held. This is contrary to guidance issued by NHS Protect, which states that 'organisations should maintain clear and unambiguous records on prescription stationery stock'. The recording and audit trail of blank prescriptions was poor and there was a risk that any theft or misuse of prescriptions would be undetected.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw 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 or infection control.

An infection control policy and procedures were in place and they covered a range of key areas such as, for example, obtaining specimens. These provided staff with guidance about the standards of hygiene they were expected to follow and enabled them to plan and implement measures to control infection. The policy had recently been reviewed.

A comprehensive infection control risk assessment and audit had recently been completed in order to identify any shortfalls or areas of poor practice. No follow up actions were identified.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We spoke with staff about what happened when patients hand in specimens to reception staff to send away for testing. They described how this happened and we found this was done in a way which minimised the risk of infection. Gloves were available to staff to use in handling specimens.

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

Arrangements had been made to ensure the safe handling of specimens and clinical waste. For example, the practice had a protocol for the management of clinical waste and a contract was in place for its safe disposal. All waste bins were visibly clean and in good working order. A legionella risk assessment had been carried out in 2013. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal). Immediate actions such as removing an unused sluice were taken following the risk assessment. The risk assessment identified there was a low risk of

legionella within the practice, and recommended the checking of the water temperature at certain sinks within the practice. The practice had not been carrying out these regular checks.

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. The equipment was regularly inspected and serviced. We saw records confirming, where appropriate, the calibration of equipment had been regularly carried out. All portable electrical equipment was routinely tested and displayed stickers indicating when the next test date was due.

The practice had recently identified that a defibrillator within the premises was not being serviced and maintained appropriately. This was because it had been unclear which organisation was responsible for maintaining it. The practice had decided to accept responsibility for this to ensure it was adequately maintained and safe to use. They were in the process of arranging a service at the time of the inspection.

Practice staff monitored the safety of the building to ensure patients were not put at risk. Regular checks of fire equipment had taken place. For example, an up-to-date fire risk assessment was in place. Weekly fire alarm tests were carried out by staff. The practice had an evacuation plan which informed staff how the building should be evacuated in the event of an emergency. The last recorded fire drill had taken place in June 2015. We checked the building and found it to be safe with no evidence of hazards.

The practice had an oxygen cylinder in place, which we saw was regularly serviced. However, there were no warning signs to highlight the dangers presented by the storage of oxygen within the practice and to highlight the storage of oxygen to emergency services, such as the fire brigade, in the event of a fire.

None of the patients we spoke to had any concerns about their safety when visiting the practice.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards they followed when recruiting clinical and non-clinical staff. DBS checks had been carried out for all clinical staff. Administrative staff had not received DBS checks but risk assessments were in place indicating why this was not felt to be necessary.

The practice manager routinely checked the professional registration status of GPs and nurses (for GPs this is the General Medical Council (GMC) and for nurses this is the Nursing and Midwifery Council) each year to make sure they were still deemed fit to practice. We saw records which confirmed these checks had been carried out. In addition, we found all clinical staff had the necessary medical indemnity insurance. (Medical indemnity insurance allows patients who have suffered harm as a result of treatment by the insured medical professional to make a claim and, where appropriate, be financially compensated for any loss experienced.)

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying on the regulated activities. Staff told us there were effective 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 that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. 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, within the reception on the front desk receiving patients or on the telephones.

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

Monitoring safety and responding to risk

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and medical emergencies.

For example, a risk assessment screening tool had been used to identify patients at risk of an unplanned admission to hospital. Steps were being taken to complete emergency care plans to help prevent older patients and patients with long-term conditions experience unnecessary admissions into hospital. Information about patients with palliative

care needs had been entered onto an electronic system which provided emergency professionals and out-of-hours clinical staff with access to information about how best to meet their needs.

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors. The practice had a health and safety policy. The assistant practice manager showed us a number of risk assessments which had been developed and undertaken; including fire and health and safety risk assessments. Risk assessments of this type helped to ensure the practice was aware of any potential risks to patients, staff and visitors and was able to plan mitigating action to reduce the probability of harm.

The practice carried out significant event reporting where concerns about patients' safety and well-being had been identified. Appropriate arrangements were in place to learn from these and to promote learning within the team.

Arrangements to deal with emergencies and major incidents

The risks associated with anticipated events and emergency situations were recognised, assessed and managed.

The practice had an up-to-date business continuity plan for dealing with a range of potential emergencies that could impact on the day-to-day operation of the practice. Staff were able to easily access it if needed. Risks were identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather and access to the building.

Staff had received training in cardio-pulmonary resuscitation (CPR). Emergency equipment was available, including an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The staff we spoke with knew the location of this equipment, and were in the process of arranging for it to be serviced.

Emergency medicines were stored securely so that only relevant staff could access them. They included, for example, medicines for the treatment of a life-threatening allergic reaction and emergency oxygen. Arrangements were in place for emergency medicines to be checked regularly to make sure they were within their expiry date and suitable for use. All the medicines we checked were in date.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff we spoke with were able to clearly explain why they adopted particular treatment approaches. They were familiar with current best practice guidance, and were able to access National Institute for Health and Care Excellence (NICE) guidelines via the practice IT system. For example, the clinical audits we looked at contained evidence that the GPs involved had been aware of changes in NICE guidance and patient safety alerts, and had ensured these were taken into account when reviewing the treatment patients had received.

From our discussions with clinical staff we were able to confirm they completed thorough assessments of patients' needs which were in line with NICE guidelines. Patients' needs were reviewed as and when appropriate. For example, staff told us that patients with long-term conditions such as COPD (chronic obstructive pulmonary disease) were invited into the practice to have their condition and any medication they had been prescribed reviewed for effectiveness.

Clinical staff had access to a range of electronic care plan templates and assessment tools which they used to record details of the assessments they had carried out and what support patients needed. The GPs and practice nurses we spoke with told us there was a process in place for developing specific templates to reflect the needs of the practice and their patients, and ensure that these were in line with NICE guidelines.

Clinical responsibilities were shared between the clinical staff. For example, one of the GPs acted as the medicines lead for the practice. The clinical staff we spoke with were very open about asking for and providing colleagues with, advice and support.

Nationally reported data taken from the Quality and Outcomes Framework (QOF) for 2013/14 showed the practice had achieved 93.2% of the points available to them for providing recommended treatments for the most commonly found clinical conditions. This was 0.9 percentage points below the Clinical Commissioning Group (CCG) average but 0.9 points above England Average. (QOF 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.)

Patients we spoke with said they felt well supported by the GPs and nursing staff with regards to making choices and decisions about their care and treatment. This was also reflected in most of the comments made by patients who completed Care Quality Commission (CQC) comment cards. Interviews with GP staff and practice nurses demonstrated the culture in the practice was that patients were referred to relevant services on the basis of need. Discrimination was avoided when making care and treatment decisions. Patients were referred on need and age, sex or race were not taken into account in this decision-making unless there was a specific clinical reason for this.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. For example, GPs held clinical lead roles in a range of areas such as mental health, learning disabilities, prescribing and for providing an enhanced service to local care homes. Other clinical and non-clinical staff had been given responsibilities for carrying out a range of designated roles, including, for example, making sure emergency drugs were up-to-date and fit for use.

We reviewed a range of data available to us prior to the inspection relating to health outcomes for patients. These demonstrated that generally the practice was performing the same as, or better than average, when compared to other practices in England.

The practice had a system in place for completing clinical audit cycles. The practice showed us a sample of two of the five clinical audits undertaken within the last year. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, the practice had audited whether they were following guidelines for prescribing antimicrobial medicines appropriately. (Antimicrobial is an agent that kills microorganisms or inhibits their growth) They identified all adult patients prescribed a type of penicillin antibiotic, co-amoxiclav, over a three month period. Improvements

were made and when the audit was repeated, the practice found this medicine was prescribed in line with guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the QOF. The practice provided us with a list of other audits and data collections they had undertaken to give reassurance in relation to the prescribing of medicines. The practice participated in the South Tyneside Clinical Commissioning Group (CCG) Quality in Prescribing Scheme, which provided a structure to their audit programme in relation to medicines.

Other clinical audits completed included a review of referrals under the two-week timescale to determine if the patient had cancer; blood pressure monitoring for patients with hypertension; and, the number of patients with COPD (chronic obstructive pulmonary disease) who had a management plan in place.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice was undertaking regular reviews of patients with diabetes for known risk factors. The practice achieved 100% of QOF points for the management of long term conditions such as asthma, heart failure, depression, and epilepsy.

The practice had systems in place to identify patients, families and children who were most at risk or vulnerable. For example, practice staff told us that they had a register of patients who had a learning disability and also those with poor mental health. They also told us that annual health checks were carried out for patients on these registers. QOF data demonstrated that registers were in place and that patients were having their health needs assessed on a regular basis.

The practice had care plans for those identified at most risk of poor or deteriorating health. This was delivered as part of an enhanced service provided by the practice. This included care plans for patients with long-term conditions who were most at risk of deteriorating health and whose conditions were less well controlled; for the most elderly and frail patients and those with poor mental health. These patients all had a named GP or clinical lead for their care. All patients over the age of 75 had been informed who their named GP was and had been given the opportunity to request another doctor if that was their preference.

Nationally reported QOF data for 2013/14 showed the practice had recorded the smoking status of 82.5% of eligible patients aged over 15. The data showed the practice was performing less well on supporting patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy. The percentage of patients aged 15 or over who were recorded as current smokers who had a record of an offer of support and treatment within the preceding 24 months was 68.3%. (This was 17.4 percentage points below CCG Average and 16.9 points below the England Average). In South Tyneside, local pharmacies provided the stop smoking service. The practice planned to increase the performance in this area by ensuring clinicians recorded when they had referred patients to this service. The practice had recorded the smoking status of 95.4% of patients with a physical or mental health condition in the preceding 12 months, compared to a national average of 95.3%.

Nationally reported QOF data for 2013/14 showed the practice had protocols that were in line with national guidance. This included protocols for the management of cervical screening, and for informing women of the results of these tests. The data showed that the records of 76.6% of eligible women, aged between 25 and 65 years of age, contained evidence they had had a cervical screening test in the preceding five years. (This compared to an England average of 81.9%.)

The QOF data also showed 92.1% of eligible women, aged 54 or under, who were prescribed an oral or patch contraceptive method, had received appropriate contraceptive advice during the previous 12 months. (This was 1.3 percentage points below the local CCG average and 2.7 points above the England average.) Overall, the data showed that the practice's performance in providing contraceptive services was 3.8 percentage points below CCG Average and 0.6 above England Average at 95.0%. The practice also performed well in relation to the provision of maternity services. Their performance (at 100%) was in line with the local CCG and 0.9% above the England average.

The practice offered an enhanced service to the local linked care home. They undertook monthly visits to the care

Good

Are services effective?

(for example, treatment is effective)

home to meet the needs of patients living there. In addition there were pre-arranged fortnightly telephone consultations with senior care home staff to discuss any on-going or acute health issues for patients.

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In accordance with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP.

Staff checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, managerial and 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. We saw there was a documented induction process for new employees.

Once a month the practice closed for an afternoon for Protected Learning Time (PLT). A part of this time was dedicated to training. Role specific training was also provided. The practice nurses had been trained to administer vaccines and had attended updates on cervical screening.

As the practice was a training practice, doctors who were in training to be qualified as GPs had access to a senior GP throughout the day for support. The practice had a comprehensive induction pack in place for trainees who were placed there. Feedback from the trainee we spoke with was positive. They commented on how well-structured and helpful this was.

Nursing staff had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, they were trained to carry out reviews of patients with long-term conditions such as asthma.

All GPs were up to date with their yearly continuing professional development requirements and all either had 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 can the GP continue to practice and remain on the performers list).

All other staff had received an appraisal, at least annually, or more frequently if necessary. During the appraisals, training needs were identified and personal development plans put into place. Staff told us they felt supported. Our interviews with staff confirmed the practice was proactive in providing staff with access to appropriate training that was relevant to their role.

We looked at the practice staff rotas. Holidays, study leave and sickness were covered in-house wherever this was possible. Although administrative and support staff had clearly defined roles, they were also able to cover tasks for their colleagues in their absence. This helped to ensure the team were able to maintain the needed levels of support services at all times.

Working with colleagues and other services

The practice worked closely with other health and social care providers, to co-ordinate care and meet patients' needs.

We saw various multi-disciplinary meetings were held. For example, a weekly multi-disciplinary meeting was held with GPs and practice nurses, and district nurses and health visitors were invited to attend. The practice had recognised relationships with district nurses and health visitors had been weakened by recent service reorganisation and long -term sickness. They had taken action to address this and strengthen relationships. For example, the linked health visitor had confirmed they would attend a meeting in July and the practice hoped this would improve communications.

The practice also held a monthly meeting at the local care and nursing home. This was attended by GPs, nursing and care staff from the care home, the community matron and staff from the local Acute Respiratory Assessment Service

Good

Are services effective?

(for example, treatment is effective)

(ARAS). There was also a pre-arranged fortnightly telephone contact with the home. This helped to share important information about patients including those who were most vulnerable and high risk.

We spoke with the staff from this service, who told us communication between the practice and the staff at the care home had improved as a result of the regular meetings. They told us both the practice and care home staff completed a form to capture information about patients prior to the meeting. This helped share important information. They told us the practice was responsive to requests for information, home visits and appointments. They told us they had a good working relationship with the practice.

We also spoke with staff from another care home in the area. They told us a meeting had recently taken place to discuss how the practice worked with staff from the home. They said this was helpful and would hopefully lead to a better understanding and improved working relationship. They told us the practice was normally responsive to requests for information and appointments. They said sometimes a request for a home visit was questioned by practice staff, but told us these had never been refused. They commented some of the GPs had "a lovely rapport" with their residents.

The practice worked with other service providers to meet patients' needs and manage complex cases. 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 to pass on, read and action any issues arising from communications with other care providers on the day they were received. The GP who reviewed these documents and results was responsible for undertaking the action required. All staff we spoke with understood their roles and felt the system in place worked well.

We found appropriate end-of-life care arrangements were in place. The practice maintained a palliative care register. We saw 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

An electronic patient record was used by all staff to coordinate, document and manage patients' care. A member of the reception team told us all staff were fully trained in using the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference

Electronic systems were in place for making referrals, and the practice made referrals 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.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. Clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. Decisions about, or on behalf of patients who lacked mental capacity to consent to what was proposed, were made in their best interests and in line with the MCA 2005. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment.

We saw a standard agenda for the multi-disciplinary meeting that took place at the local care home. We saw that issues of capacity; and current and new applications for Deprivation of Liberty Safeguards were discussed at this meeting. (These safeguards make sure that a care home or hospital only restricts someone's liberty safely and correctly, and that this is done only when there is no other way to take care of that person safely.)

GPs we spoke with showed they were knowledgeable about how and when to carry out Gillick competency assessments of children and young people. 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 for documenting consent for specific interventions. Patients we spoke with reported they felt involved in decisions about their care and treatment.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

New patients were offered a 'new patient check'. The initial appointment was scheduled with the healthcare assistant, 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). The patient was then offered an appointment with a GP if there was a clinical need, for example, a review of medication.

Information on a range of topics and health promotion literature was available to patients in the waiting areas. This included information about screening services, smoking cessation and child health. Patients were encouraged to take an interest in their health and take action to improve and maintain it.

The practice's website also provided links to other websites and information for patients on health promotion and prevention.

We found patients with long-term conditions were recalled to check on their health and review their medications 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 told us this system worked well and prevented any patient groups from being overlooked. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening.

The practice offered a full range of immunisations for children, as well as travel and flu vaccinations, in line with current national guidance. The practice performed similarly to other practices within the local CCG area on rates for a number of child hood vaccinations. For example, Mumps, Measles and Rubella (MMR) vaccination rates for five year old children were 93.8% compared to an average of 97.0% in the local CCG area. Infant Men C vaccination rates for two year old children were 98.8% compared to 98.2% across the CCG; and for five year old children were 97.9% compared to 98.5% across the CCG. The practice had recently taken over responsibility for sending out and booking appointments for childhood immunisations. They thought this would help improve immunisation rates. They told us they monitored this data regularly to identify areas where they could improve. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was higher at 57.9% than the England average of 52.3%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with seven patients during our inspection. They were all happy with the care they received. Patients told us they were treated with respect and were positive about the staff. They told us they would recommend the practice to family and friends. Comments left by patients on the six CQC comment cards we received also reflected this.

We looked at data from the National GP Patient Survey, published in January 2015. This demonstrated that patients were mostly satisfied with how they were treated and that this was with compassion, dignity and respect. We saw that 97.1% (compared to 92.2% nationally) of patients said they had confidence and trust in their GP.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate, understanding and caring, while remaining respectful and professional. Many of the comments on the Care Quality Commission (CQC) comment cards referred to the helpful nature of staff. This was reflective of the results from the National GP Survey where 91% of patients felt the reception staff were helpful, compared to a national average of 86.9%.

Patients' privacy, dignity 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. A private room or area was also made available when people wanted to talk in confidence with the reception staff. This reduced the risk of personal conversations being overheard.

We saw staff who worked in the reception areas made every effort to maintain patients' privacy and confidentiality. Voices were lowered and personal information was only discussed when absolutely necessary. Telephone calls from patients were taken by administrative staff in an area where confidentiality could be maintained.

Staff were familiar with the steps they needed to take to protect patients' 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 that conversations taking place in those rooms could not be overheard.

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

The National GP Patient Survey information we reviewed showed patients were satisfied with questions about their involvement in planning and making decisions about their care and treatment. For example, the survey showed 79.5% of respondents said the GP and 63.5% said the nurse was good at involving them in decisions about their care. This compared to a national average of 74.6% and 66.2% respectively. 81.1% of patients felt the GP and 75.6% felt the nurse was good at explaining treatment and results compared to a national average of 82.0% and 76.7% respectively.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the six CQC comment cards we received was also positive and supported these views.

We saw that access to interpreting services was available to patients, should they require it. Staff said when a patient requested the use of an interpreter, they could either book an interpreter to accompany the patient to their appointment or, if it was an immediate need, then 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

We observed patients in the reception area being treated with kindness and compassion by staff. None of the

Good

Are services caring?

patients we spoke with, or those who completed CQC comment cards, raised any concerns about the support they received to cope emotionally with their care and treatment.

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 85.6% of those surveyed thought the GPs they saw or spoke to was good at treating them with care and concern. Similarly, 81.8% thought nurses did.

We did not see any evidence during the inspection of how children and young people were treated by staff. However, neither the patients we spoke to, nor those who completed CQC comment cards, raised any concerns about how staff looked after children and young people.

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups.

The practice routinely asked patients if they had caring responsibilities. This was then noted on the practice's computer system so it could be taken into consideration by clinical staff.

Support was provided to patients during times of bereavement. Families were offered a visit from a GP at these times for support and guidance. Staff were kept aware of patients who had been bereaved so they were prepared and ready to offer emotional support. The practice also offered details of bereavement services. Staff we spoke with in the practice recognised the importance of being sensitive to patients' wishes at these times.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided a service for all age groups. They covered patients with diverse cultural and ethnic needs and those living in deprived areas. We found GPs and other staff were familiar with the individual needs of their patients and the impact of the local socio-economic environment. Staff understood the lifestyle risk factors that affected some groups of patients within the practice population. We saw the practice referred people to the local services, where the aim was to help particular groups of patients to improve their health. For example, smoking cessation programmes, and advice on weight and diet.

Staff told us that 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 medical system. This meant the GP or nurses would already be aware of this and any additional support could be provided, for example, a longer appointment time.

Longer appointments were made available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the national GP patient survey published in January 2015 confirmed this. 92.8% of patients felt the doctor gave them enough time, compared to a local Clinical Commissioning Group (CCG) average of 90.8% and England average of 85.3%. 84.7% felt they had sufficient time with the nurse, compared with a local CCG average of 82% and England average of 80.2%.

The practice had a well-established Patient Participation Group (PPG) which met face-to-face. We spoke with two members of the group who said they felt the practice valued their contribution. They spoke highly of the quality of care and service they had experienced personally. The practice shared relevant information with the group and ensured their views were listened to and used to improve the service offered at the practice. For example, PPG members told us changes had been made as a result of their feedback, for example, a suggestion box had been installed and sanitising hand gel had been moved to a more prominent position to encourage patients to follow good hand hygiene.

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 include evening appointments. This helped to improve access for those patients who worked or were in full-time education.

Services had been designed to reflect the needs of the diverse population served by the practice. The practice had access to and made frequent use of translation services, for those patients who did not speak English as a first language.

The premises and services had been adapted to meet the needs of people with disabilities. All patient facilities were at ground floor level and there was wheelchair and step-free access.

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. Accessible toilet facilities were available for all patients attending the practice, including baby changing facilities.

Access to the service

Appointments were available between Monday to Friday from 8:30am to 6:00pm, with late opening on alternate Tuesdays and Wednesdays from 8:30am to 8:00pm. We looked at information from the National GP Patient Survey which demonstrated the majority of patients were satisfied with availability of appointments. For example, 88.5% of patients said they were able to see or speak to someone last time they tried, compared to a local CCG and England average of 85.4%. Also, 98.4% of patients said they found their last appointment was 'very' or 'fairly' convenient, compared to an average of 93.4% in the local CCG area and 91.8% across England.

Consultations were provided face-to-face at the practice, over the telephone, or by means of a home visit by the GP. This helped to ensure patients had access to the right care at the right time. The National GP Patient Survey results showed that 85.7% of patients were satisfied with opening hours, compared to a national average of 75.7%. Patients rated the ease of getting through to the surgery very highly, with 93.7% saying they found it easy to get through to someone at the surgery on the phone, compared to a local CCG average of 80.3%, and an England average of 71.8%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

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.

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.

The complaints policy was outlined in the practice leaflet and was available on their website. The practice also had a comments box situated in the entrance foyer to enable patients to provide feedback about the service provided.

Of the seven patients we spoke with, and the feedback we received from the six CQC comment cards completed by patients, none raised concerns about the practice's approach to complaints.

We looked at the summary of complaints that had been received in the 12 months prior to our inspection. There were three within this period, of which two had been anonymous. We found these had been reviewed as part of the practice's formal annual review of complaints. 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. Changes had been implemented where necessary. For instance, the practice had taken steps to ensure patients were informed of any delays in appointment times as a result of a complaint.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had a business plan in place, with key business objectives that were reviewed annually. The plan set out the key priorities for the practice and how they would be achieved. It was evident in discussions we had with staff throughout the day that it was a shared vision and was fully embedded in staff's day-to-day practice.

We spoke with 10 members of staff and they all knew the provision of high quality care for patients was the practice's main priority. They also knew what their responsibilities were in relation to this and how they played their part in delivering this for patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared drive on any computer within the practice. We looked at a sample of these policies and procedures and saw they had been reviewed regularly and were up-to-date.

The practice held regular staff, clinical and practice meetings. We looked at minutes from recent meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) as an aid to measure their performance. The QOF data for this practice showed they were performing in line with the local Clinical Commissioning Group (CCG) and England averages. Performance in these areas was monitored by the practice manager and GPs, supported by the administrative staff. We saw that QOF data was discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice had completed a number of clinical and internal audits. The results of these audits and re-audits demonstrated outcomes for patients had improved.

Leadership, openness and transparency

The practice had a clear leadership structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control and the GP had leads in areas such as long-term conditions, prescribing and mental health. We spoke with 10 members of staff and they were all clear about their own roles and responsibilities.

We saw from minutes that staff meetings were held regularly. Staff told us that there was an open culture within the practice and they were actively encouraged to raise any incidents or concerns about the practice. This ensured honesty and transparency was at a high level.

We found the practice leadership proactively drove continuous improvement and staff were accountable for delivering this. We found there was good staff morale in the practice.

There was a clear and positive approach to seeking out and embedding new ways of providing care and treatment. For example, the practice was investigating the reasons for patient attendance at Accident and Emergency Departments (A&E) where patients could have otherwise been seen at the practice to support the reduction of unnecessary A&E attendance. The business plan in place identified priorities and supported the practice with improving quality within the practice.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff, for example, whistleblowing and safe recruitment policies. These were easily accessible to staff via a shared intranet on any computer within the practice.

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

The practice had gathered feedback from patients through patient surveys, comments boxes and complaints received.

The practice had a patient participation group (PPG), which they referred to as their patient reference group. The group met every three to four months and input was gathered by face-to-face meetings and email.

The practice manager showed us the analysis of the last patient survey they had carried out, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The key priority identified for the practice were to highlight to patients the 'Think Pharmacy First' (a scheme for accessing treatment for minor ailments via pharmacy

Are services well-led?

Good

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

services); making sure patients who were referred to services at a hospital were given a choice as to which hospital they were referred to; and, undertaking an audit to identify the number of patients who failed to attend phlebotomy appointments. The practice published an annual report into the work of the PPG and this was available on the practice website.

NHS England guidance states 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 at the reception desk and instructions for patients on how to give feedback. The practice manager told us the comments and feedback would be reviewed regularly. The practice analysed this data on a monthly basis and published this information on their website. They showed us the results for May 2015. The feedback was extremely positive, with 12 of the 15 patients who responded to this survey extremely likely to recommend the service to friends or family.

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions on a daily basis. Staff we spoke with told us they regularly 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 and engaged in the practice to improve outcomes for both staff and patients.

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 would not hesitate to raise any concerns they had.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw that regular appraisals took place. Staff members had personal development plans. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings to ensure the practice improved outcomes for patients. Staff meeting minutes showed these events were discussed, with actions taken to reduce the risk of them happening again.