Northumberland Park Medical Group, Shiremoor Resource Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Northumberland Park Medical Group, Shiremoor Resource Centre on 24 March 2015. Overall the practice is rated as good.

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

Our key findings 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 and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The majority of patients said they were able to get an appointment with a GP when they needed one, with urgent appointments available the same day.
- The practice offered pre-bookable early morning appointments on Tuesdays, Wednesdays and Fridays which improved access for patients who worked full time through the week.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure in place for clinical areas and staff felt supported by management. The practice proactively sought feedback from staff and patients, which they acted on.
- The administrative and support staff worked well together as a team.

We saw the following areas of outstanding practice:

- The practice had achieved significantly higher cervical screening rates (93.8%) compared to the national average (81.9%). The practice nurse led on this and opportunistically reviewed their patients' last screening date, when this was appropriate to do so, during their patients' appointments. If they noticed they were approaching their due date, they would offer to make an appointment for the patient while they were there. This showed the practice were not simply reliant on the central recall process for cervical screening, but were taking responsibility for managing this process locally too.
- In total, we were told that 866 patients registered with the practice had some form of care plan agreed and in place. This represented 16% of the practice population and included all patients with chronic diseases, those identified to be at high risk of hospital admission and patients identified as being in vulnerable circumstances.

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

Importantly the provider should:

- Improve the systems used to centrally record, monitor and review significant events within the practice.
- Continue to review the appointments process as feedback from a number of sources indicated it was difficult to get a same day appointment with a GP when patients felt their need was urgent.
- Endeavour to improve team working within the practice between clinical and non-clinical staff on management and business matters.
- Review its arrangements for nursing provision; especially to provide cover for holidays.

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 their responsibilities to raise concerns, and to report incidents and near misses. We found significant events were recorded, investigated and learned from on an individual basis, however systems were not in place to record or review these collectively within the practice. Risks to patients were assessed and well managed. Disclosure and Barring Service (DBS) checks had been completed for all staff that required them. There were no formal arrangements in place to provide nursing cover when the practice nurse was on holiday.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring its effectiveness and had achieved 97.4% of the points available. This was slightly above than the local average of 96.8% and 3.9% above the national average. 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. The clinical audits completed by the practice measured whether agreed standards had been achieved and made recommendations and took action where standards were not being met. The practice had achieved significantly higher cervical screening rates (93.8%) compared to the national average (81.9%). The practice nurse led on this and opportunistically reviewed their patients' last screening date.

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. For example, the National GP Patient Survey showed 86% of practice respondents said the last GP they saw or spoke to involved them in decisions about their care and 89% said the last nurse they saw or spoke to involved them in

Summary of findings

decisions about their care. Both these results were higher than the local Clinical Commissioning Group (CCG) area and national averages. The CCG averages were 79% and 70%, with the national averages being 75% and 66% respectively. Patients said they were treated with compassion, dignity and respect and they felt involved in decisions about their care and treatment. A total of 866 patients registered with the practice had some form of care plan agreed and in place. This represented 16% of the practice population and included all patients with chronic diseases, those identified to be at high risk of hospital admission and patients identified as being in vulnerable circumstances. 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. Most patients said they found it easy to make an appointment with a GP; however feedback from a number of sources suggested it was difficult at times to get a same day appointment with a GP when patients felt their need was urgent. Patients were able to book longer appointments on request and pre-bookable appointments with a GP were available from 7.00am two days per week and from 7.30am 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 and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. They had clear aims and objectives. Staff were clear about their responsibilities in relation to these. There was a clear leadership structure in place for clinical matters and staff felt supported by management. Team working within the practice between clinical and non-clinical staff on management and business matters could be improved. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which they acted on. The practice had a small but active patient participation group (PPG) and was looking to expand this. 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. They offered proactive, personalised care to meet the needs of the older people in its population. For example, all patients over the age of 75 had a named GP and 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 maintained a palliative care register and offered immunisations for pneumonia and shingles to older people.

People with long term conditions

Outstanding 

The practice is rated as outstanding for the care of people with long-term conditions. The practice nurse had a lead role in chronic disease management and patients at risk of hospital admission were identified as a priority. In total, we were told that 866 patients registered with the practice had some form of care plan agreed and in place. This represented 16% of the practice population and included all patients with chronic diseases, those identified to be at high risk of hospital admission and patients identified as being in vulnerable circumstances. Patients were recalled for reviews of their conditions by telephone and it was felt this had improved patient uptake rates, especially for annual asthma reviews. The practice were unable to provide us with any data to support this, however they were performing above local and national averages for the Quality and Outcomes Framework (QOF). Longer appointments and home visits were available when needed. Patients at high risk of hospital admission had structured reviews to check that their health and medication needs were being met. For those people with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Appointments, including daily telephone appointments, were available with the on call GP each day to allow time for contact with other services to support patients who were vulnerable, had poor mental health or long term conditions should they need a more multidisciplinary team approach to their on-going care.

Summary of findings

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 monthly basis and discussed at clinical meetings with the support of the Community Macmillan Nurse.

The practice had adopted the 'Year Of Care' (YoC) programme for its diabetic patients, which the practice nurse led on. The YoC is about improving care for people with long-term conditions in the NHS. It is based upon care planning and providing support for patients to self-manage their condition. The YoC approach has been recognised and adopted by NICE in the quality standard statement pertaining to care planning.

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. The practice ran weekly baby clinics for immunisations and immunisation rates were generally above average for the local Clinical Commissioning Group (CCG). For example, Men C vaccination rates for one year old children were 92.6% compared to 86.4% across the CCG and Men C Booster rates for two year old children were 97.3% compared to 96.8% across the CCG. 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. We saw good examples of joint working with midwives and health visitors.

The practice had achieved significantly higher cervical screening rates (93.8%) compared to the national average (81.9%). The practice nurse led on this and opportunistically reviewed their patients' last screening date.

The practice had just started to write to patients on turning 16 years old to invite them in to the practice for a health check with the healthcare assistant. Routine contraceptive and emergency sexual health care was provided. The practice were closely supported by the one-to-one centre in Shiremoor for a more extensive range of services, such as coil and implant fitting and more detailed sexual health checks.

The practice was supported by a paediatric nurse led walk in clinic for patients with young children who wanted to be seen urgently. The practice also facilitated the review of patients from this clinic who were felt to need a GP review that day.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). 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 and by using a smartphone app.

The practice offered extended opening hours three mornings per week; two days a week from 7.00am and from 7.30am on a third day. Patients could pre-book appointments to see a GP at these times and could pre-book appointments to see the practice nurse from 7.30am on Tuesday mornings. This made it easier for people of working age to get access to the service. NHS health checks were offered to patients between the ages of 40 and 74 and the practice also carried out joint injections as part of its minor surgery service.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances, including those with a learning disability. One of the GPs was identified as the lead for the practice for these patients. Patients with learning disabilities were invited to attend the practice for annual health checks. The practice offered longer appointments for people with a learning disability, if required.

Appointments, including daily telephone appointments, were available with the on call GP each day to allow time for contact with other services to support patients who were vulnerable, had poor mental health or long term conditions should they need a more multidisciplinary team approach to their on-going care.

Patients who were carers and those who were cared for were identified within the practice's electronic systems. The practice had plans in place to invite these patients to attend for an annual health check from April 2015 onwards.

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.

The practice was able to refer patients with drug or alcohol problems to a local service. They had also completed an audit on the appropriate prescribing of vitamin B preparations for patients who had problems with alcohol abuse. This had resulted in them receiving improved care and treatment.

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. They carried out advance care planning for patients with dementia.

The practice had recently validated its register of patients living with dementia by using a dementia toolkit. This had confirmed the practice had a low number of patients identified as living with this condition. As a result, it was decided at a practice meeting that the practice nurse would ask their older patients with chronic diseases about memory problem as part of their annual check-ups. GPs would also ask the same questions to their older patients opportunistically.

The practice had access to local counselling services and could also access an initiative called 'Wellbeing in North Tyneside' run by a local NHS Foundation Trust which offered a range of services for patients including cognitive behavioural therapy (CBT). CBT is a talking therapy that can help you manage your problems by changing the way you think and behave. The practice also had access to the local Improving Access to Psychological Therapies (IAPT) team. The IAPT programme supports the frontline NHS in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders. Information and leaflets about services were made available to patients within the practice.

Appointments, including daily telephone appointments, were available with the on call GP each day to allow time for contact with other services to support patients who were vulnerable, had poor mental health or long term conditions should they need a more multidisciplinary team approach to their on-going care.

Summary of findings

What people who use the service say

We spoke with 18 patients in total; 16 patients on the day of the inspection and two patients before the inspection who were members of the practice's Patient Participation Group (PPG). 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 generally happy with the appointments system, although some patients were not as satisfied with the arrangements for same day appointments with a GP.

We reviewed 42 CQC comment cards completed by patients prior to the inspection. The large majority were complimentary about the practice, staff who worked there and the quality of service and care provided. Of the 42 CQC comment cards completed, 28 patients made direct reference to the caring manner of the practice staff. Words used to describe the approach of staff included pleasant, courteous, professional, friendly, helpful, caring and reliable.

The latest National GP Patient Survey showed patients were mostly satisfied with the services the practice offered. The results were mainly in line with or better than other GP practices within the local Clinical Commissioning Group (CCG) area and nationally. The practice scored slightly lower than the local and national averages for patients' satisfaction with opening hours and on their experience of making and convenience of appointments received. 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 – 85% (CCG average 86%, national average 85%);
- The proportion of respondents who said the last GP they saw or spoke to was good at explaining tests and treatments – 93% (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 – 86% (CCG 79%, national 75%);
- The proportion of respondents who said they had confidence and trust in the last GP they saw or spoke to – 98% (CCG 95%, national 92%);
- The proportion of respondents who said the last nurse they saw or spoke to was good at explaining tests and treatments – 88% (CCG 82%, 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 – 89% (CCG 70%, national 66%);
- The proportion of respondents who said they had confidence and trust in the last nurse they saw or spoke to – 98% (CCG 89%, national 86%).

These results were based on 114 surveys that were returned from a total of 351 sent out; a response rate of 32%.

Areas for improvement

Action the service SHOULD take to improve

The provider should:

- Improve the systems used to centrally record, monitor and review significant events within the practice.
- Continue to review the appointments process as feedback from a number of sources indicated it was difficult to get a same day appointment with a GP when patients felt their need was urgent.
- Endeavour to improve team working within the practice between clinical and non-clinical staff on management and business matters.
- Review its arrangements for nursing provision; especially to provide cover for holidays.

Summary of findings

Outstanding practice

- The practice had achieved significantly higher cervical screening rates (93.8%) compared to the national average (81.9%). The practice nurse led on this and opportunistically reviewed their patients' last screening date when this was appropriate to do so during their patients' appointments. If they noticed they were approaching their due date, they would offer to make an appointment for the patient while they were there. This showed the practice were not simply reliant on the central recall process for cervical screening, but were taking responsibility for managing this process locally too.
- In total, we were told that 866 patients registered with the practice had some form of care plan agreed and in place. This represented 16% of the practice population and included all patients with chronic diseases, those identified to be at high risk of hospital admission and patients identified as being in vulnerable circumstances.

Northumberland Park Medical Group, Shiremoor Resource Centre

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 a specialist adviser with experience of practice management.

Background to Northumberland Park Medical Group, Shiremoor Resource Centre

The practice is based within the Shiremoor Health Centre. The practice serves those living in Shiremoor, Backworth, West Allotment, Holystone, Earsdon, Wellfield, Holywell and parts of Seaton Delaval. They provide services from the following address and this is where we carried out the inspection:

Shiremoor Resource Centre, Earsdon Road, Shiremoor, Newcastle Upon Tyne, Tyne and Wear NE27 0HJ.

The surgery in Shiremoor provides all of its services to patients at ground floor level. The practice offers on-site parking including disabled parking bays, accessible WC's and step-free access. They provide services to around 5,200 patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

The practice has three GPs in total; two GP partners and a salaried GP. The practice is a training practice, with one attached GP Registrar (a fully qualified doctor, allocated to the practice as part of their three year specialist training). There is also one practice nurse, one healthcare assistant, a practice manager and a team of administrative support staff.

The CQC intelligent monitoring system placed the area in which the practice was located in the fifth 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 very similar to 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 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?
- 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 24 March 2015. We visited the practice's surgery in Shiremoor. We spoke with 18 patients and a range of staff from the practice. We spoke with the practice manager, two GPs, one practice nurse and some of the practice's administrative and support staff. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 42 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.

Good

Are services safe?

Our findings

Safe Track Record

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. Comments from patients who completed Care Quality Commission (CQC) comment cards reflected this. Two patients commented directly about safety; they both said they felt the environment was safe and hygienic.

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 and comments and complaints received from patients. Staff we spoke with were aware of their responsibility to raise concerns, and how to report incidents and near misses. For example, we saw records of an incident where it had been identified that a medication review for a patient should have been more thorough.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This 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, however systems were not in place to record or review these collectively within the practice. As a result of this we were unable to establish or confirm the number of events recorded during the last 12 months in total. We saw each significant event was recorded, investigated and discussed at practice meetings attended by GPs, nursing and administrative staff. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff, were aware of the system for raising significant events.

We saw incident forms were available on the practice's shared drive computer system. Once completed these were sent to the practice manager who managed and monitored them. We saw evidence of action taken as a result. 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. The alerts were reviewed and sent to the appropriate staff for their attention by a designated member of the administrative team. The practice manager provided support with this. 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. Staff said alerts were also discussed at meetings to ensure they were aware of any relevant to their area of work and where action needed to be taken.

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 in all of the consultation rooms and reception areas.

The practice had a dedicated GP partner appointed as the lead in safeguarding vulnerable adults and another for safeguarding children. These people had been trained to child safeguarding level three to enable them to fulfil this role. The other GP had been trained to this level too. Staff we spoke with were aware of who the leads for the practice were and who to speak with if they had any safeguarding concerns.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, any children the practice had concerns about and victims of domestic violence were coded on the system.

Good

Are services safe?

A chaperone policy was in place and a notice was displayed in the patient waiting area to inform them of their right to request one. The practice manager said chaperoning was only carried out by the practice nurse and healthcare assistant, however some of the administrative staff we spoke with said they had been asked to chaperone by one of the GPs. They had not been trained for this role and the description they gave indicated they did not fully understand the responsibilities and expectations of the role. The practice manager was not aware of this arrangement and assured us this would stop with immediate effect. The practice nurse and healthcare assistant 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 all communications about the patient including scanned copies of communications from hospitals.

Medicines Management

We checked a sample of vaccines stored in the medicine refrigerator 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 fridge were safe to use.

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. The practice did not hold stocks of controlled drugs (CDs), however the CD register included an entry for a medicine the practice stocked that was not required to be recorded in it. The practice pharmacist confirmed after the inspection this would be recorded in a 'stock book' in future.

We saw records of correspondence between the GPs and practice pharmacist that noted the actions taken or planned in response to reviews of prescribing data. For example, we saw the practice's performance against some national QIPP indicators had been reviewed (The Quality, Innovation, Productivity and Prevention (QIPP) programme is a large-scale programme developed by the Department of Health to drive forward quality improvements in NHS care). The review showed that potential improvements could be made in relation to the prescribing of an antibiotic medicine used to treat urinary tract infections (UTIs), with an audit planned to reinforce this.

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

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw blank prescription forms were stored securely. The arrangements were in line with best practice guidance issued by NHS Protect. Detailed records were kept to show when prescription forms were used, however records were not kept of all prescriptions received into the practice.

Cleanliness & Infection Control

We saw the premises were clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Regular checks on the quality of cleaning were completed. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice nurse was the designated led for infection control and they were supported by a member of the administrative support staff who completed bi-monthly audits. The audits included checking that sharps boxes (boxes used to safely dispose of sharps and needles) had been signed and dated on assembly and were not overfilled, clinical waste bags were being used as required and antibacterial hand gel was available throughout the practice. The member of staff who completed the audits was due to leave the practice soon and arrangements had already been made for the handover of this responsibility to the healthcare assistant. All staff received training about infection control specific to their role, and updates were provided internally or at 'Time-Out' training sessions.

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 were available for staff to use and staff were able to describe how they would use these

Good

Are services safe?

in order to comply with the practice's infection control policy. Staff who worked on reception were able to describe the process to follow for the receipt of patient specimens. There was also a policy for needle stick injuries and the disposal and management of clinical waste.

Hand hygiene techniques signage was displayed throughout the practice. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Spillage kits were available to deal with any biological fluid spills.

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 the practice was 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. We saw evidence of calibration of relevant equipment; for example, weighing scales and blood pressure monitoring equipment. The practice manager said their blood pressure monitoring machines had recently been renewed. All portable electrical equipment had last been tested in April 2012.

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).

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There were arrangements in place for members of staff to cover each other's annual leave. The practice used locum GPs to cover for their GPs holidays, however there were no formal arrangements in place to cover the practice nurses' annual leave. We were told one of the GP partners' spouse was a registered nurse and had provided some cover in the past. They were kept on the practice's payroll and maintained their professional registration and kept their training up to date. The practice had a comprehensive locum pack in place.

Staff told us there was enough staff to maintain the smooth running of the practice and there was always enough staff on duty to ensure patients were kept safe. We saw records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. The practice had recently completed a review of staffing numbers. This had led to some new staff being appointed to provide additional cover at the end of the working week.

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, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff and patients to see.

Identified risks had been recorded and each risk was assessed with mitigating actions noted to manage the risk. We saw where risks had been identified; action plans had been drawn up to reduce these risks. For example, fire risk assessments were in place. Risk assessments were completed by the landlord.

Staff were able to identify and 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. A new member of staff had completed their training at a neighbouring practice.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing staff had received training in basic life support. Emergency equipment was available. This included a defibrillator (used to attempt to restart a person's heart in an emergency) and oxygen. The defibrillator was shared between the three GP practices based in the same building and was kept in the reception

Good

Are services safe?

area of the building. Records of daily checks of the defibrillator and monthly checks of the oxygen were up-to-date. 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. All the medicines we checked were in date and fit for use.

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 and loss of access to the building. It also included a detailed list of contact details. The plan was updated annually between January and March, or more frequently if information such as people's contact details changed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could describe the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE). We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs and these were reviewed when appropriate. For example, a GP we spoke with showed us how they routinely referred to NICE guidelines, local guidelines and information gathered from the internet during their consultations.

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

Patients we spoke with said they felt well supported by the GPs 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.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with the clinical staff showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making unless there was a clinical reason for doing so.

Management, monitoring and improving outcomes for people

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

The practice were able to show us some clinical audits that had been completed. We looked at five examples of clinical audits that had been undertaken in the last few years. The audits included repeat audit cycles, where the practice was able to demonstrate the changes resulting since the initial audits had been carried out. For example, the practice had completed an audit of patients prescribed Vitamin B Compound and Vitamin B Compound Strong for the treatment of the physical complications of alcohol use disorders. The aim of the audit was to ensure compliance with NICE guidance, which stated that Vitamin B Compound Strong and Vitamin B Compound were no longer recommended for the treatment of the physical complications of alcohol-use disorders, due to a lack of efficacy. The first audit identified 21 patients who were prescribed Vitamin B Compound Strong or Vitamin B Compound for this reason. After the initial findings, it was agreed that one of the GPs would lead on this piece of work. This GP would review each patient and decide whether or not a discontinuation of these medicines was appropriate. A second clinical audit was completed seven months later which demonstrated that all the original 21 patients on these medicines had had these medicines discontinued. One new patient had recently joined the practice on this medicine and a task had been sent to the GP to review them once their patient notes were received into the practice. This demonstrated that all of the original patients identified were now having medicines prescribed as per the NICE guidance.

Other areas that had been audited in recent years included a review of patients prescribed Newer Oral Anticoagulants (NOAC's), an audit of prescribing inhaled therapy in people with stable Chronic Obstructive Pulmonary Disease (COPD) and patient waiting times in the GP surgery.

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 97.4% of the total QOF target in 2013/2014, which was above the national average of 93.5%. Specific examples to demonstrate this included:

Good

Are services effective?

(for example, treatment is effective)

- Performance for dementia related indicators was better than the national average (100% compared to the national average of 93.4%).
- Performance for asthma related indicators was better than the national average (100% compared to the national average of 97.2%).
- Performance for cancer related indicators was better than the national average (100% compared to the national average of 95.5%).

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

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, the practice had reduced its prescribing of benzodiazepines (a group of medicines that are sometimes used to treat anxiety, sleeping problems and other disorders) since 2010 in comparison to other practices. Data also showed the practice to be low referrers. One of the GPs we spoke with felt the in-house service offered for joint injections may contribute to this.

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). Staff had not completed fire training recently; however the practice manager had completed fire marshal training in February 2015. 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).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. We saw records in staff files of appraisals completed within the last six months and were told others were planned within the next month. Staff interviews confirmed that the practice was supportive in providing training and funding for relevant courses. For example, one of the staff we spoke with said they had asked for more reception-based training recently and they were confident this would be provided.

Nursing staff had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, the practice nurse was trained to administer vaccines and immunisations and carry out reviews of patients as part of the practice's chronic disease management programme.

The administrative and support staff had clearly defined roles, however they were also able to cover tasks for their colleagues. We spoke with the secretary who showed us they had put together a 'blue file' which referred to all of the tasks they completed throughout the month. This had been put in place to ensure that any member of staff who covered their duties (for example when they took annual leave or during unplanned absence) were clear about what needed doing and when. 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 who saw these documents and results was responsible for the action required. All 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 on a monthly basis to discuss the needs of high risk patients, for example, those with end of life care needs. These meetings were attended by a range of healthcare professionals including district nurses, community matrons, Macmillan nurses and health visitors and decisions about care planning were recorded. The practice's GPs attended these meetings and felt this system worked well. They remarked on the usefulness of the meetings as a means of sharing important information. The practice maintained lists of patients who had learning disabilities, those at high risk of unplanned admissions and patients diagnosed as living with dementia. These and other at risk patients were reviewed and discussed at the MDT meetings. A 'traffic light system' was used to indicate those patients that required more intense input from the clinical team.

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. The secretary led on Choose and Book within the practice and appointments were arranged and confirmed with patients before they left the practice. Patients were also offered the opportunity to register and book their own appointments from home.

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 that 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).

There was a practice policy for recording consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. This was also the process followed for the fitting of contraceptive implants, such as Implanon. Verbal consent was taken from patients for routine examinations.

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 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 above the averages for the local Clinical Commissioning Group (CCG). For example, Men C vaccination rates for one year old children were 92.6% compared to 86.4% across the CCG and Men C Booster rates for two year old children were 97.3% compared to 96.8% 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 helped to ensure the staff with responsibility for inviting people in for review managed this effectively. We were told this worked well to prevent any patient groups from being overlooked. All the staff we spoke with told us the practice telephoned patients when they were due to be recalled, rather than send them letters. Staff felt this system worked well and the QOF data for the practice we reviewed supported this claim.

Processes were also in place to ensure the regular screening of patients was completed, for example, cervical

Good

Are services effective?

(for example, treatment is effective)

screening. Performance in this area for 2013/14 was much higher than the national average at 93.8% (the national average was 81.9%). We spoke with the practice nurse who led on this. They were aware the practice performed well in this area, but were not aware of how well compared to the national average. They told us they opportunistically reviewed their patients' last screening date when this was appropriate to do so during their appointments. If they noticed they were approaching their due date, they would offer to make an appointment for the patient while they were there. This showed the practice were not simply reliant on the central recall process for cervical screening, but were taking responsibility for managing this process locally too.

There was a range of information on display within the practice reception area. This included a number of health promotion and prevention leaflets, for example on smoking, alcohol consumption and sexual health. The practice's website included links to a range of patient information, including for travel immunisations, NHS health checks and the management of long term conditions.

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 mostly reflected this. Of the 42 CQC comment cards completed, 28 patients made direct reference to the caring manner of the practice staff. Words used to describe the approach of staff included pleasant, courteous, professional, friendly, helpful, caring and reliable.

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

The reception area fronted directly onto the patient waiting area. We saw staff who worked in this 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 a separate area where confidentiality could be maintained.

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. Staff we spoke with said a spare room 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.

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 in the locked records room. Staff had completed information governance training and were aware of the need to keep records secure.

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 (published in January 2015) showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, the survey showed 86% of practice respondents said the last GP they saw or spoke to involved them in decisions about their care and 89% said the last nurse they saw or spoke to involved them in decisions about their care. Both these results were higher than the local Clinical Commissioning Group (CCG) area and national averages. The CCG averages were 79% and 70%, with the national averages being 75% and 66% respectively.

The majority of the most recently published National GP Patient Survey results for the practice were a little above the local CCG area and national averages. For example, 93% of respondents said the last GP they saw or spoke to was good at listening to them and 90% of respondents reported the same for the last nurse they saw or spoke to. The CCG averages were 92% and 83%, with the national averages being 87% and 79% respectively. The practice had also scored well in terms of patients feeling they had confidence and trust in the last GP (98% of respondents) or nurse (98%) they saw or spoke to. This compared to the CCG averages of 95% and 89%, with the national averages being 92% and 86% respectively.

Feedback from patients we spoke with reflected the results from the latest National GP Patient Survey. 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.

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 number of patients had been identified as being at high

Good

Are services caring?

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 example, plans that had been put into place for a number of at risk patients were described to us by the GPs we spoke with.

The practice manager said that 866 patients registered with the practice had some form of care plan agreed and in place. This represented 16% of the practice population and included all patients with chronic diseases, those identified to be at high risk of hospital admission and patients identified as being in vulnerable circumstances.

Staff told us that translation services were available for patients who did not have English as a first language. We also saw that support was available for patients with hearing difficulties and the practice encouraged patients with visual impairments to bring their guide dogs with them to appointments.

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 commented the GPs and staff knew them well and were caring and supportive.

Notices in the patient waiting room signposted patients to a number of support groups and organisations. The practice website included information to support its patients. For example, information was provided for patients who had drug and alcohol problems and a range of information about self-help mental health services was displayed. The practice maintained a carer's register and records of cared for patients and the practice manager said the practice intended to invite all of these patients in for an annual health check starting from April 2015.

Support was provided to patients during times of need, such as in the event of bereavement. A GP would carry out a home visit, or at the very least a telephone call was made to bereaved relatives at these times to offer support and guidance. 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

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.

The practice engaged regularly with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. For example, the practice had agreed with the CCG to share responsibility for a number of patients in a local nursing home with another practice locally.

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Staff said patients were encouraged to see the same GP if possible, which enabled good continuity of care. Patients could access appointments face-to-face in the practice, receive a telephone consultation with a GP or be visited at home. Longer appointments were available for people who needed them on request.

The practice had a palliative care register and had 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 had a patient participation group (PPG) and met with them on a monthly basis. We spoke with two members of the group ahead of the inspection. They said the group was quite small, however they were actively looking to expands its membership beyond the current level of four patients. The chair of the group had attended one of the practice meetings recently to discuss and formalise plans for this. The group members we spoke with said feedback from the group was well received by the practice and a number of changes had been made by them in response to patient feedback. For example, the group had been involved with influencing some changes that had been made to the appointments system.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, opening times had been extended to provide pre-bookable early morning appointments with a GP three days a week and on one day a week with the practice nurse. This helped to improve access for those patients who worked full time. The majority of the practice population were English speaking patients but access to translation services were available if they were needed. The practice maintained registers for patients with caring responsibilities, patients with learning disabilities and patients receiving palliative care. All of these measures helped to ensure that all of their patients had equal opportunities to access the care, treatment and support they needed.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was situated on the ground floor. The main entrance doors had been automated to improve access and all of the treatment and consulting rooms could be accessed by those with mobility difficulties. The reception desk had an area where the counter had been lowered to enable patients who used wheelchairs to speak face to face with the reception staff. We saw that the waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. This made movement around the practice easier and helped to maintain patients' independence. The patient toilets could be accessed by patients with disabilities. Dedicated car parking was provided for patients with disabilities in the car park close to the entrance. An induction loop system was in place for patients who experienced hearing difficulties.

Access to the service

Most of 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 always get an appointment within that week; no problem getting appointments; booking system is good and always get an appointment. Four of the 42 patients who filled in CQC comment cards were not as satisfied. They made comments such as perhaps it could be easier to get an appointment sooner, it is difficult to get an appointment and can't get an appointment; have to ring at 8.30am and 12pm and can't get through. All of the patients we spoke with did say they had been able to see a GP the same day if their need had been urgent.

Good

Are services responsive to people's needs?

(for example, to feedback?)

As a result of some of the feedback we received from patients, we sat with the administrative staff at 12pm to observe what happened when the practice released some appointments that could be booked to see a GP later that day. We saw the telephone lines became very busy just before 12pm and by 12.05pm all of the appointments released at 12pm had been taken. Shortly after this time the telephone lines became very quiet again. This suggested that patients were aware they only had a very small window of opportunity to book a same day appointment with a GP at that time. Staff did say that if patients rang after all of the appointments were taken (and still needed to be seen that day) they would be told to come to the practice for the start of the afternoon surgery, but they would have to wait to be seen.

The latest results from the National GP Patient Survey published in January 2015 were mixed in terms of patient's feedback regarding appointments. 85% of respondents said they were able to get an appointment to see or speak to someone the last time they tried. This was just below the local Clinical Commissioning Group (CCG) average of 86% and the same as the national average. In contrast, the practice had achieved lower than local and national average results from patients on their experience of making an appointment and the convenience of their last appointment. 69% of respondents said their experience of making an appointment was good (compared to the CCG average 78%, national average 74%) and 88% said their last appointment was convenient (compared to the CCG average 93%, national average 92%).

The practice also conducted their own annual patient survey and this too had highlighted some concerns around appointments in the past. We saw the score for patient satisfaction with appointments had improved by 9% during the last two and a half years, with improvements also achieved in response to patients being asked what their chances were of seeing a doctor or nurse within 48 hours. An audit had also been completed by one of the GPs on waiting times in the surgery. All of this showed the practice had responded and were attempting to improve access for their patients.

We looked at the practice's appointments system in real-time on the afternoon of the inspection. We saw there were not any appointments available to be booked with a GP that day. Routine appointments to see the nurse and healthcare assistant were available within three working days and to see a GP were available to be booked within four working days. The practice offered telephone consultations with GPs too and these were available to be booked on the day. The practice was supported by a paediatric nurse led walk in clinic for patients with young children who wanted to be seen urgently. The practice also facilitated the review of patients from this clinic who were felt to need a GP review that day.

The practice was open from 8.30am to 6.00pm Monday and Thursday; 7.00am to 6.00pm Tuesday and Wednesday and from 7.30am to 6pm on Friday. The practice's extended opening hours on in the mornings 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 also included appointments with a GP or nurse. Home visits were made to those patients who were unable to attend the practice.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments online. Patients could also book appointments by using a smartphone app. 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, they were automatically transferred to the out-of-hours service. 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 was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Information about services and how to complain was available and easy to understand.

We saw the practice had received two complaints in the last 12 months and these had been investigated in line with their complaints procedure. Where mistakes had been

Good

Are services responsive to people's needs?

(for example, to feedback?)

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.

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 42 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 its patients with the highest standard of personal health care and to seek continuous improvement in the health of their patients. This was reflected in the practice's statement of purpose, along with a number of other aims including being courteous, professional and acting with integrity and complete confidentiality.

We spoke with a variety of practice staff including the practice manager, GPs, practice nurse 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 aim – making sure their patients got the best treatment and options for treatment available.

Governance Arrangements

The practice had policies and procedures in place to govern activity and these were available to staff on the shared drive on any computer within the practice. We looked a sample of these policies and procedures and our discussions with staff demonstrated they had read and understood these. The practice manager said formal records of staff having seen, read and understood the practice's policies were not kept. They understood this could be improved. All of the policies and procedures we looked at had been reviewed regularly 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 performing in line with or above national standards. We saw that QOF data was regularly 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 initial telephone request to attend the practice for reviews of their long-term conditions.

The practice had completed a number of clinical audits which it used to monitor quality and systems to identify where action should be taken. The clinical audits completed measured whether agreed standards had been achieved or made recommendations and took action where standards were not being met. The results of completed audits were discussed at meetings, where responsibility for leading on any actions to be taken were agreed.

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.

The practice held regular meetings for staff. 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 leadership structure in place with named members of staff in lead roles for clinical areas. For example, there was a lead nurse for infection control and a GP was the lead for safeguarding. 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.

Although there was clear leadership and evidence of collaborative working on clinical matters, we were told by the GPs and practice manager this was not always the case for management and business matters. One of the GPs told us they did not get involved with any practice management issues and they left this to the practice manager and one of the other GPs. The practice manager said they knew the GP partners met informally on a weekly basis; however they were not invited to attend.

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 health and safety and prescribing, which were in place to support staff. We saw policies were available for all staff to access electronically. 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 among the administrative and support staff. We saw from minutes that team meetings were held regularly. Staff told us they had the opportunity and were happy to raise issues at team meetings.

Are services well-led?

Good

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

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 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 in the practice to improve outcomes for both staff and patients.

The staff we spoke with, including the practice manager and GPs told us forward planning was discussed informally. None of the GPs were approaching retirement; however the practice manager said the options available at that time had been discussed. The practice manager spoke of a desire to increase the patient list size; however they appreciated that they would need to recruit clinicians to be able to sustain the level of services offered. We saw plans were in place to develop and improve the services provided. For example, the practice were looking to invite patients identified as carers in for an annual health check from April 2015 onwards Staff said they felt listened to and their opinions were valued and contributed to shaping and improving the service.

The practice had a patient participation group (PPG). The PPG had a small number of members; however plans were in place to promote the group in the coming months in order to increase the number and diversity of patients within the group. The PPG met monthly and representatives from the practice always attended to support the group. We spoke with some members of the PPG and they felt the practice supported them fully with their work and took on board and reacted to any concerns they raised. For example, the practice had made some changes as a result of feedback from the PPG. This included changes to the appointments system. Patient feedback from the practice's own patient survey was also routinely reviewed at group meetings, including any actions taken by the practice in response.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they wouldn't hesitate to raise any concerns they had. Staff said significant events were handled consistently and 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. Staff meeting minutes showed 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. GPs met with colleagues at locality and Clinical Commissioning Group (CCG) meetings. They attended learning events and shared information from these with the other GPs in the practice. The practice nurse said they had attended bi-monthly meetings with other practice nurses locally which provided them with further education and support. They had also tried to set up monthly meetings with practice nurses from the other two practices located in the same building.

Information and learning was shared verbally between staff and the practice also used their intranet system to store and share information. Learning needs were identified through the appraisal process and staff were supported with their development. For example, the practice nurse said they had been supported to complete a course on interpreting spirometry results. A spirometer measures the volume and speed of air that can be exhaled and inhaled and is a method of assessing lung function.