Dr Sreeni Vis-Nathan

Quality Report

Horsley Hill Road,
South Shields,
Tyne and Wear,
NE33 3ET
Tel: 0191 4552093
Website: www.ravensworthsurgery.co.uk

Date of inspection visit: 2 June 2015
Date of publication: 09/07/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Dr Sreeni Vis-Nathan on 2 June 2015

Overall, we rated the practice as good. Specifically, we found the practice was good for providing caring, effective, responsive services and well led services. However, improvements are required to ensure safe services are provided.

Our key findings were as follows:

- Feedback from patients was positive; they told us staff treated them with respect and kindness;
- Patients reported good access to the practice. The proportion of patients who were able to get an appointment when they wanted was above average (78% compared to the national average of 73%);
- Patients we spoke with told us they felt they had sufficient time during their appointment;
- Patients' needs were assessed and care was planned and delivered following best practice guidance;
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed;
- There was a clear leadership structure and staff felt supported by the management team. The practice actively sought feedback from patients;
- The practice was clean and hygienic, and good infection control arrangements were in place.

There were some areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure relevant recruitment checks are carried out on new staff;
- Ensure staff receive training relevant to their role, including fire safety and infection control.

In addition the provider should:

- Review the business continuity plan to ensure it reflects current arrangements;

Summary of findings

- Take steps to monitor equipment to ensure it is in date and suitable for use;
- Maintain clear records on prescription stationery stock, in line with guidance from NHS Protect.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services.

The nationally reported data we looked at as part of our preparation for this inspection did not identify any concerns relating to safety. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The GP partners and practice management team took action to ensure lessons were learned from any incidents or concerns, and shared these with staff to support improvement. However, appropriate recruitment checks on staff had not been undertaken prior to their employment. Not all staff had received training in infection control and fire safety. We also found equipment at one site that was out of date. Although good medicines management arrangements were in place, the practice did not maintain clear records on prescription stationery stock.

Are services effective?

Good

The practice is rated as good for providing effective services.

Care and treatment was being delivered in line with current published best practice. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE), and the local clinical commissioning group (CCG). Arrangements had been made to support clinicians with their continuing professional development. There were systems in place to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services.

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

The National GP Patient Survey from January 2015 showed the majority of patients were happy with the care received. 93% and 92% respectively of patients said they had confidence and trust in their GP and nurse (compared to 93% and 86% nationally). However,

Summary of findings

83% said the last GP they saw or spoke to was good at listening to them (compared to the national average of 88%) and 67% said the last GP they saw or spoke to was good at involving them in decisions about their care (national average 74%).

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Nationally reported data showed patient outcomes were broadly in line with, or better than the local Clinical Commissioning Group (CCG) and national averages. Findings from the National GP Patient Survey, published in January 2015 showed 78% (compared to 73% nationally) of respondents were able to get an appointment or speak to someone when necessary. The practice scored very highly on the ease of getting through on the telephone to make an appointment (86% of patients said this was easy or very easy compared to the national average of 71%).

Services had been planned to meet the needs of the key population groups using the practice. The practice had good facilities and was well equipped to treat patients and meet their needs. There was a virtual patient participation group (PPG), who held the practice to account. There was an accessible complaints procedure, with evidence demonstrating the practice made every effort to address any concerns raised with them.

Are services well-led?

Good

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

The leadership, management and governance of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision which was shared by all staff. There was an effective governance framework in place, which focused on the delivery of high quality care. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients and had set up a virtual patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Good

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

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

The practice offered personalised care to meet the needs of the older people in its population. The practice had written to patients over the age of 75 years to inform them who their named GP was. The practice was responsive to the needs of older people, and offered home visits for health checks and flu vaccinations. GPs had good links to the local care home and regularly visited patients living there.

One of the practice nurses carried out holistic home visits to older people. This was more convenient for patients and gave them more time to discuss any concerns.

Staff within the practice worked closely with other health professionals to provide care and support for older people, including, district nurses and social workers.

People with long term conditions

Good

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

The practice had a high proportion of patients with multiple long-term conditions and had planned for, and made arrangements to deliver, care and treatment to meet their needs. Patients with long-term conditions were offered regular reviews and an annual check of their health and wellbeing, or more often where this was judged necessary by the clinical staff. One of the GPs was the lead for long-term conditions and so kept an overview of the patients and their treatment needs. A 'shared care' model had been implemented where patients were engaged in the decision making pathways.

Where possible, those patients with multiple conditions were offered a 'combination review' whereby all of their health conditions were monitored at one consultation. There were urgent appointments available at each nurse clinic in order to give rapid access to nursing support and reassurance.

Summary of findings

Nationally reported QOF data (2013/14) showed the practice had achieved generally good outcomes in relation to the conditions commonly associated with this population group. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with asthma This was 0.3 percentage points above the local CCG average and 2.8 points above the national average. However, there were some conditions where the scores were below average. For example, for peripheral arterial disease. The practice achieved 83.2% of the available points, which was 2.6 points below the CCG average and 8.0 points below the national average.

Families, children and young people

Good

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

Systems were in place to identify and follow-up children who were considered to be at risk of harm or neglect. For example, the needs of all at-risk children were regularly reviewed at practice multidisciplinary meetings, which involved child care professionals such as school nurses and health visitors.

Appointments were available outside of school hours and reception staff had been trained to take note of any urgent problems and notify the doctor about an unwell child or parental concern. The premises were suitable for children and babies. Arrangements had been made for new babies to receive the immunisations they needed. Vaccination rates for 12 month and 24 month old babies and five year old children were generally in line with the local CCG area.

Pregnant women were able to access an antenatal clinic provided by healthcare staff who were attached to the practice. Nationally reported QOF data (2013/14) showed that the practice had obtained 100% of the QOF points available for providing recommended maternity services. The data also showed that child development checks were offered at intervals consistent with national guidelines.

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, 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 which reflected the needs for this age group.

Summary of findings

Patients could order repeat prescriptions and book appointments on-line. The practice was open between 8:00am and 6:00pm Monday and Friday. There were extended opening hours at the Jarrow branch on a Tuesday between 6:00pm and 8:00pm.

The practice provided additional services such as health checks for the over 40's, smoking cessation advice clinics and travel vaccinations.

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.

Systems were in place in place to identify patients, families and children who were at risk or vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. These patients were offered regular reviews. Staff worked with the local learning disability team and took on board suggestions for better communication methods. 'Easy read' letters had been created to welcome patients to the practice.

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

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.

The practice kept a register of patients with mental health needs which was used to ensure they received relevant checks and tests. Patients suffering new episodes of depression were regularly reviewed and encouraged to attend the practice to plan the best treatment options with the clinicians.

Nationally reported QOF data (2013/14) showed the practice had obtained 89.2% of the points available to them for providing recommended care and treatment for patients with dementia. This was slightly below the local CCG and England averages.

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

Summary of findings

What people who use the service say

We spoke with 15 patients during our inspection. We spoke with people from different age groups, who had varying levels of contact and had been registered with the practice for different lengths of time.

We reviewed 12 CQC comment cards which had been completed by patients prior to our inspection.

All patients were complimentary about the practice, the staff who worked there and the quality of service and care provided. They told us the staff were very caring and helpful. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were happy with the appointments system.

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

- GP Patient Survey score for opening hours – 79% (national average 76%);
- Percentage of patients rating their ability to get through on the telephone as very easy or easy – 86% (national average 71%);
- Percentage of patients rating their experience of making an appointment as good or very good – 77% (national average 73%);
- Percentage of patients rating their practice as good or very good – 78% (national average 86%);
- The proportion of patients who would recommend their GP surgery – 82% (national average 78%).

Areas for improvement

Action the service MUST take to improve

- Ensure relevant recruitment checks are carried out on new staff;
- Ensure staff receive training relevant to their role, including fire safety and infection control.

Action the service SHOULD take to improve

- Review the business continuity plan to ensure it reflects current arrangements;
- Take steps to monitor equipment to ensure it is in date and suitable for use;
- Maintain clear records on prescription stationery stock, in line with guidance from NHS Protect.

Dr Sreeni Vis-Nathan

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Sreeni Vis-Nathan

Dr Sreeni Vis-Nathan is registered with the Care Quality Commission to provide primary care services and is located in South Tyneside.

The practice provides services to around 5,850 patients from two locations:

- Horsley Hill Road, South Shields, Tyne and Wear, NE33 3ET
- The Medical Centre, Wear Street, Jarrow, Tyne and Wear, NE32 3JN

We visited both addresses as part of the inspection.

The practice has one GP partner, one salaried GP (one male and one female), two practice nurses (both female), a healthcare assistant, a practice manager, and 12 staff who carry out reception and administrative duties. The salaried GP was in the process of applying to become a partner in the practice.

The practice is part of South Tyneside clinical commissioning group (CCG). The practice is situated in areas of relatively high deprivation. The population in the Jarrow area is made up of a higher than average proportion of patients over the age of 50. The practice population profile at South Tyneside is in line with national averages.

The South Shields surgery is located in a converted two storey building. The Jarrow branch is within a purpose built two storey building. All patient facilities at both sites are located on the ground floor. On-site parking, disabled parking, a disabled WC, wheelchair and step-free access is available.

Opening times at South Shields are between 8:00am and 6:00pm every weekday except Thursday when the surgery is open between 8:00am and 1:00pm. The Jarrow branch is open between 8:00am and 6:00pm everyday weekday except Tuesday when it is open between 8:00am and 8:00pm. Patients can book appointments in person, on-line or by telephone.

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

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

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

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

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

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. This did not highlight any significant areas of concern 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 2 June 2015. We spoke with 15 patients and eight members of staff from the practice. We spoke with and interviewed one GP, the practice manager, a practice nurse, the healthcare assistant and four 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 12 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.

Requires improvement

Are services safe?

Our findings

Safe track record

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

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

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

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

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

Learning and improvement from safety incidents

The practice was open and transparent when there were near misses or when things went wrong. There was a system in place for reporting, recording and monitoring significant events. We spoke with the practice manager about the arrangements in place. They told us that all staff had responsibility for reporting significant or critical events. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Records of those incidents were kept on the practice computer system and made available to us. We found details of the event, steps taken, specific action required and learning outcomes and action points were noted. There was evidence that significant events were discussed at staff meetings to ensure learning was disseminated and implemented.

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

We discussed the process for dealing with safety alerts with the practice manager. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. Any alerts were initially received by the practice manager; information was then forwarded to clinicians and other staff where necessary. Each alert was discussed at a clinical meeting to ensure staff were aware of any necessary action. We saw minutes confirming these discussions had taken place.

Reliable safety systems and processes including safeguarding

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

There was an identified member of staff with a clear role to oversee safeguarding within the practice. Staff we spoke with said they knew which of the GPs was the safeguarding lead. This GP was responsible for ensuring staff were aware of any safeguarding cases or concerns.

Requires improvement

Are services safe?

There was a system on the practice's electronic records to highlight vulnerable patients. Children and vulnerable adults who were assessed as being at risk were identified using READ codes. These codes alerted clinicians to their potential vulnerability (clinicians use READ codes to record patient findings and any procedures carried out).

The clinicians discussed ongoing and new safeguarding issues at their weekly meetings, and also held regular meetings with health visitors. The staff we spoke with had a good knowledge and understanding of the safeguarding procedures and what action should be taken if abuse was witnessed or suspected.

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

There were no records to demonstrate that the GPs had completed any training on safeguarding vulnerable adults. Some nursing and administrative staff had carried out some on line training, but not the whole team.

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

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

Medicines management

There were clear systems in place to manage medicines. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. We saw medicines were in date and good systems to check expiry dates were implemented. There were procedures to ensure expired and unwanted medicines were disposed of in line with waste regulations.

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

Vaccines were administered by nurses using patient group directions (PGDs) and patient specific directions (PSDs). These are specific guidance on the administration of medicines authorising nurses to administer them. We saw up-to-date copies of directions were held by each of the nurses.

There was an effective system in place to ensure patients' medicines were regularly reviewed. The re-issuing of medicines was closely monitored, with patients invited to book a 'medication review', where required. One GP was responsible for all medication reviews; this ensured a clear overview of the individual patient and of the practice's prescribing habits.

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

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol covered, for example, how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

Cleanliness and infection control

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

One of the practice nurses was the nominated infection control lead. We saw there was an up to date infection control policy and detailed guidance for staff about specific issues. For example, hand hygiene and use of protective

clothing. All of the staff we spoke with about infection control said they knew how to access the practice's infection control procedures. The infection control lead attended annual training courses on infection control. However, none of the administrative staff or the other members of the nursing team had received any training. The practice manager was aware of this and had made plans to ensure all staff would be booked onto training courses.

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

The practice employed its own cleaning staff. We looked at records and saw the domestic staff completed cleaning schedules, on a daily, weekly, monthly and annual basis. Cleaning staff did not have access to colour coded mops; the practice manager said these would be ordered immediately.

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

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

At the time of the inspection the practice did not have an up-to-date legionella risk assessment (legionella is a type of bacteria found in the environment which can contaminate water systems in buildings and can be potentially fatal). However, we saw records confirming that an external company was due to carry out some testing within the following two weeks.

Equipment

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

Minor surgery was carried out at the practice. We saw there were appropriate arrangements for the disposal of single-use surgical instruments. However, some of the equipment for use in the treatment room at Jarrow was out of date. We discussed this with the practice manager; they told us the out of date equipment would be disposed of immediately and arrangements put into place to monitor stocks.

Staffing and recruitment

The practice had an up to date recruitment policy in place that outlined the process for appointing staff but this was not always followed.

Most of the staff had worked at the practice for many years. We looked at the recruitment files for the two newest members of staff. We found that some of the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) 2010 was not available. We saw that pre-employment checks, such as obtaining a full work history, evidence of identity and references had not always been carried out prior to staff starting work. The practice could therefore not be sure of a person's good character or previous experience. The practice manager told us they had obtained verbal references but these had not been documented.

The practice manager and practice nurses had been subject to DBS checks. All of the GPs had undergone DBS

checks as part of their application to be included on the National Medical Performers' List. All performers are required to register for the online DBS update service which enables NHS England to carry out status checks on their certificate. DBS checks were in progress for all other staff that were in contact with patients.

We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

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

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

Appropriate staffing levels and skill-mix were provided by the practice during the hours the service was open. The practice regularly monitored the number of extra urgent appointments used to ensure that staffing levels were sufficient to meet demands.

The practice had systems in place to manage and monitor health and safety. The fire alarms and emergency lights were regularly tested and there were regular fire evacuation drills. We saw records confirming these checks had been carried out.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with regarding emergency procedures knew the location of this equipment. However, staff had not undertaken fire safety training and there were no designated fire wardens.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. The defibrillator and oxygen were accessible and records of weekly checks were up to date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Copies of the plans were held by the practice manager and GPs at their homes so contact details were available if the buildings were not accessible. The plan was dated 2012; the practice manager told us they would review the contents and update if any changes were required.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. GPs demonstrated an up-to-date knowledge of clinical guidelines for caring for patients. There was a strong emphasis on keeping up-to-date with clinical guidelines, including guidance published by professional and expert bodies. The practice undertook regular reviews of their referrals to ensure current guidance was being followed.

The clinician we interviewed was able to describe and demonstrate how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. New guidelines and the implications for the practice's performance and patients were discussed at weekly clinical meetings.

We found from our discussions with the GP and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, the practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. We spoke with staff about how the practice helped people with long term conditions manage their health. They told us that there were regular clinics where patients were booked in for recall appointments. This ensured patients had routine tests, such as blood or spirometry (lung function) checks to monitor their condition.

Nationally reported data taken from the Quality and Outcomes Framework (QOF) for 2013/14 showed the practice had an overall score of 91.1%, compared to 95.3% locally and 93.5% nationally. (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 such as diabetes and implementing preventative measures. The results are published annually.)

We were told patient safety alerts and guidelines from NICE were discussed at relevant team meetings to enable shared learning. We saw minutes of practice meetings where new guidelines were shared with staff, the implications for the practice's performance were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure each patient received support to achieve the best health outcome for them.

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 filled in CQC comment cards.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in managing, monitoring and improving outcomes for patients. For example, GPs held clinical lead roles in a range of areas, including cancer and safeguarding. 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.

The practice had a system in place for completing clinical audit cycles, which led to improvements in clinical care. We saw a number of clinical audits had recently been carried out. The results and any necessary actions were discussed at the clinical team meetings. This included an audit of patients with atrial fibrillation (a heart condition) to ensure they had been prescribed the most effective medication. A review was undertaken of all patients on the atrial fibrillation register. This showed that the proportion of patients eligible for a particular medicine who had been prescribed it was only 11%. Two further re-audits were carried out and showed that performance had improved; the proportion of patients receiving the medicine had increased to 61%.

The practice used an analysis tool, Reporting Analysis and Intelligence Delivering Results (RAIDR) to look at trends and compare performance with other practices. We reviewed a range of data available to us prior to the inspection relating to health outcomes for patients. These demonstrated that performance was generally in line with other practices in England in most areas.

Good

Are services effective?

(for example, treatment is effective)

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also ensured that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Role specific training was provided. The GPs attended nationally run training courses to help them deliver appropriate care and treatment to patients. The practice nurses had been trained to administer vaccines and had attended updates on cervical screening. Staff told us they had sufficient access to training and were able to request further training where relevant to their roles. The GP partner demonstrated a high level of dedication and commitment to the patients and the practice.

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

All other staff had received an appraisal, at least annually, or more frequently if necessary. During the appraisals, training needs were identified and future career development plans were discussed. Staff told us they felt supported.

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

Appropriate arrangements had been made to ensure the practice was appropriately staffed. The practice had a holiday protocol which helped to ensure that sufficient numbers of clinical and non-clinical staff were always rostered on duty. The practice employed two long-term locums; succession planning was discussed as part of ongoing practice reviews (succession planning helps teams to plan in advance for any foreseeable changes in their staff group).

The patients we spoke with were complimentary about the staff. Staff we spoke with and observed were knowledgeable about the role they undertook.

Working with colleagues and other services

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

We saw various multi-disciplinary meetings were held. For example, regular palliative care meetings were held, which involved practice staff and the district and palliative care nurses. The practice safeguarding lead had good relationships with social services, health visitors and school nurse services. Staff commented they worked well with the local CCG and felt supported. The lead GP was a member of the local clinical commissioning group (CCG) board.

Staff worked with the local learning disability team and took on board suggestions for better communication methods. 'Easy read' letters had been created to welcome patients to the practice.

The practice worked very closely with the local care home. A GP carried out regular visits to the home and had dedicated time set aside each week to phone and check on patients. Information about patients was shared on a timely basis to help meet their needs.

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

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 had been fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used electronic systems to communicate with other providers. For example, making referrals to hospital

Good

Are services effective?

(for example, treatment is effective)

services using the Choose and Book system (the Choose and Book system enables patients to choose which hospital they will be seen in and allows them to book their own outpatient appointments). Staff reported this system was easy to use.

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

Correspondence from other services such as blood results and letters from the local hospital including discharge summaries, was received both electronically and by post. Staff we spoke with were clear about their responsibilities for reading and taking action to address any issues arising from communications from other care providers. They understood their roles and how the practice's systems worked. There was a 'team' approach which meant staff increased their knowledge and were aware of the mapping of a patient's pathway. These arrangements also acted as a safeguard against any missed information.

Consent to care and treatment

Before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. There was a practice policy on consent, this provided guidance for staff on when to document consent.

Staff were all able to give examples of how they obtained verbal or implied consent. We saw where necessary, written consent had been obtained, for example, for minor surgical procedures.

The GP 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.

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. Decisions about or on behalf of patients who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the MCA. The GP described the procedures they had followed where people lacked capacity to make an informed decision about their treatment.

Health promotion and prevention

The practice identified people who needed ongoing support and were proactive in offering this. This included carers, those receiving end of life care and those at risk of developing a long term condition. For example, there was a register of all patients with heart failure. Nationally reported QOF data (2013/14) showed that the practice had obtained 100% of the points available to them for providing recommended clinical care and treatment to heart failure patients. The data indicated that 100% of patients with heart failure were receiving a particular type of medicine. This was 0.1 percentage points above the local CCG average and 1 point above the England average.

The QOF data showed the practice had obtained 100% of the points available to them for providing cervical screening to women. This was 2.5 percentage points above both the local CCG and England averages. However, the scores in relation to how the practice supported patients to stop smoking were below average. The data showed the practice had obtained 79.4% of the points available to them for providing support with smoking cessation. This was 15.3% below the CCG average and 14.3% below the national average.

Patients with long term conditions were reviewed each year, or more frequently as necessary. Arrangements were in place to contact patients who did not attend to ensure they received a review. The local CCG had agreed to employ local district nurses to carry out home visits to those patients who were housebound. The lead GP told us they did not want to adopt that approach within the practice, therefore the practice's own nursing staff carried out home visits to carry out the reviews. They felt this approach meant staff knew their own patients well. The GP was also the lead for long-term conditions and so kept an overview of the patients and their treatment needs. A 'shared care' model had been implemented where patients were engaged in the decision making pathways.

Where possible, those patients with multiple conditions were offered a 'combination review' whereby all of their health conditions were monitored at one consultation. There were urgent appointments available at each nurse clinic in order to give rapid access to nursing support and reassurance.

New patients were offered a 'new patient check', with a nurse, to ascertain details of their past medical histories, social factors including occupation and lifestyle,

Good

Are services effective?

(for example, treatment is effective)

medications and measurement 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 of the practice. This included information about screening services, smoking cessation and child health. Patients were encouraged to take an interest in their health and to take action to improve and maintain it.

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

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

There was a patient-centred culture. We reviewed the most recent data available for the practice regarding patient satisfaction. This included information from the national GP survey (January 2015). The scores in relation to patients' last appointment with a doctor or nurse were in line with or above national averages. For example,

- 93% of patients said they had confidence and trust in their GP (compared to 93% nationally)
- 92% of patients said they had confidence and trust in their nurse (compared to 86% nationally)
- 83% of patients said the GP treated them with care and concern (82% nationally)
- 78% of patients said the nurse treated them with care and concern (compared to 78% nationally).

We spoke with 15 patients during our inspection. All were happy with the care they received from the practice and said their dignity and privacy was respected. Patients commented that the practice provided a very good service.

We reviewed 12 CQC comment cards which had been completed by patients prior to the inspection. Patients had completed all of the CQC comment cards issued to the practice. Comments were all positive. Words used to describe the approach of staff included pleasant, friendly, helpful and respectful.

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

We saw the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. Staff spoke quietly so their conversations could not be overhead. Staff were aware of how to protect patients' confidential information. There was a room available if patients wanted to speak to the receptionist privately.

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

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

Care planning and involvement in decisions about care and treatment

Patients told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand. Patients were satisfied with the level of information they had been given. We reviewed the 12 completed CQC comment cards, patients felt they were involved in their care and treatment.

The results of the National GP Patient Survey from January 2015 showed most patients felt involved in their care and treatment, but the scores were all below the national average:

- 83% said the last GP they saw or spoke to was good at listening to them (national average 88%)
- 67% said the last GP they saw or spoke to was good at involving them in decisions about their care (national average 74%)
- 75% said the last nurse they saw or spoke to was good at listening to them (national average 79%)
- 65% said the last nurse they saw or spoke to was good at involving them in decisions about their care (national average 67%).

We discussed these results with the practice manager and one of the GPs. They felt this had been due to the staffing changes over the past year.

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

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our visit told us staff responded compassionately when they needed help and provided support when required. The CQC comment cards we received were also consistent with this feedback. For example, patients commented that staff were caring and took time to help and support them.

We saw there was a variety of information on display throughout both surgeries. There were several noticeboards with a range of information regarding common health conditions and local support groups. The practice routinely asked patients if they had caring responsibilities and had set up a carer's register to help them identify and make sure they were receiving the professional support they needed. Staff had recently attended an educational event on carers to help improve their understanding and approach to caring for carers.

Patients suffering new episodes of depression were regularly reviewed and encouraged to attend the practice to plan the best treatment options with the clinicians.

Letters were sent to patients when they were discharged from hospital. These letters offered the opportunity for patients to ask for help and support or for further information about their condition.

The lead GP carried out all home visits to palliative care patients. They told us they didn't think it was appropriate for locums to carry out these visits. The GP was available to patients at any time of the week, should they have needed them to visit. This provided continuity of care for the patient and their families. If a patient had been identified as needing palliative care then the practice noted this on their patient record and they were prioritised if they wanted an appointment or home visit.

Support was provided to patients during times of bereavement. The same support given to palliative care patients was given to families after a bereavement. Staff told us that if families had suffered bereavement, this was followed up by the practice, with a letter in the first instance and either a visit or telephone call depending upon the circumstances. Staff were aware of the difficulties faced by families and provided additional support, for example, any death certificates were hand delivered.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to the needs of the local population. The lead GP and many of the staff had worked at the practice for many years which enabled good continuity of care. The majority of patients we spoke with and those who filled out CQC comment cards said they felt the practice was meeting their needs. For example, patients could access appointments face-to-face in the practice, receive a telephone call back from a clinician or be visited at home.

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 patient's medical record. 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.

Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the National GP Patient Survey from January 2015 reflected this; 85% (86% nationally) of patients thought the doctors and 81% (81% nationally) thought nurses gave them enough time.

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of older patients and those with long-term conditions. One of the GPs was the overall lead, but the practice nursing team was responsible for delivering most of the chronic disease care and treatment needed by patients. The practice offered patients with long-term conditions, such as asthma and diabetes, an annual check of their health and wellbeing, or more often where this was judged necessary by the GP.

Some of the patients registered with the practice were housebound, and had several long-term conditions. The practice nurse carried out full reviews for these patients at their homes.

The Quality and Outcomes Framework (QOF) data (2013/14) showed the practice had obtained 100% of the points available to them for providing recommended care and treatment to patients needing palliative care (this was 3.3 percentage points above the national average). The practice kept a register of patients who were in need of palliative care and their IT system alerted clinical staff about those who were receiving this care. QOF data showed that multi-disciplinary team (MDT) meetings took place at least every three months, to discuss and review the needs of each patient on this register. Staff told us these meetings included relevant healthcare professionals involved in supporting patients with palliative care needs, such as community nurses and health visitors.

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

The practice had planned its services to meet the needs of the working age population, including those patients who had recently retired. They provided an extended hours service from 6:00pm until 8:00pm one evening a week, to facilitate better access to appointments for working patients. The practice website provided patients with information about how to book appointments and order repeat prescriptions.

The practice engaged regularly with the clinical commissioning group (CCG) and other practices across South Tyneside to discuss local needs and service improvements that needed to be prioritised.

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

Tackling inequity and promoting equality

The practice had recognised the needs of the different groups in the planning of its services. For example, the computer system used by the practice alerted GPs if patients were at risk of harm, or if a patient was also a carer. Where patients were identified as carers we saw that information was provided to ensure they understood the various avenues of support available to them should they need it.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

The practice was aware of the needs of older people, for example, those with dementia. Good links with the local care home were evident. One of the GPs carried out weekly visits and told us they had good communication with these patients, their families and the nursing staff.

Free parking was available directly outside each building. The doors providing access to the surgery at Jarrow were automated. The entrance doors were not automated at South Shields and there was no doorbell or information about how to summon support to gain entry. We saw the consulting rooms were large with easy access for all patients. There were also toilets that were accessible to disabled patients and baby changing facilities for use. A hearing loop system was in place for patients who experienced difficulties with their hearing.

Only a small minority of patients did not speak English as their first language. Staff told us that usually the patient was accompanied by a family member or friend who would translate for them. There were arrangements in place to access telephone interpretation services for urgent appointments or book an interpreter to accompany patients where appointments were booked in advance.

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

Access to the service

The practice was open between 8:00am and 6:00pm Monday and Friday. There were extended opening hours at the Jarrow branch on a Tuesday between 6:00pm and 8:00pm.

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

Reception staff had been trained to take note of any urgent problems and notify the doctor, for example, of an unwell child or parental concern. This was confirmed when we observed reception staff taking calls from patients; patients were offered appointments on the same day.

The most recent National GP Patient Survey (January 2015) showed 78% (compared to 73% nationally) of respondents were able to get an appointment or speak to someone when necessary. The practice scored very highly on the ease of getting through on the telephone to make an appointment (86% of patients said this was easy or very easy compared to the national average of 71%). Patients we spoke with confirmed they were able to get an urgent appointment at short notice.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The local out of hours provider was Northern Doctors Urgent Care (NDUC).

We found the practice had an up to date booklet which provided information about the services provided, contact details and repeat prescriptions. The practice also had a clear, easy to navigate website which contained detailed information to support patients.

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. The complaints policy was outlined in the practice leaflet and was available on the practice's website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

None of the 15 patients we spoke with during the inspection said they had felt the need to complain or raise concerns with the practice. None of the 12 CQC comment cards completed by patients indicated they had felt the need to make a complaint.

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

The practice had received six formal complaints in the 12 months prior to our inspection and 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. Staff we spoke with felt involved in the process.

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; this was stated within the statement of purpose. The vision was 'to deliver a high level of medical care to all of our registered patients in a clean, suitably equipped environment, in a flexible and innovative way, to meet patient's choice and to reflect changing political and economic circumstances'.

Staff told us they knew and understood what the practice was committed to providing and what their responsibilities were in relation to these aims. They all told us they put the patients first and aimed to provide person-centred care. We saw that the regular staff meetings helped to ensure the vision and values were being upheld within the practice.

Practice development sessions were held annually and were attended by the GPs and the practice manager. These meetings were used to review any changes that needed to be made to take account of contractual changes in the GP contract, to reaffirm what the practice did well, what its priorities were for the year ahead, and what changes needed to be made to make further improvements to patient outcomes. The practice management team were aware of the problems recruiting GPs and had regular succession planning meetings to agree future clinical staffing levels.

Governance arrangements

Arrangements for assessing, monitoring and addressing risks were in place. For example, the practice had a business continuity plan to help ensure the service could be maintained in the event of foreseeable emergencies. The practice had a number of policies and procedures in place to govern activity. These were available to staff via the shared drive on any computer within the practice. The policies and procedures had been reviewed regularly and were up-to-date.

There was a management team in place to oversee the practice. The practice used the Quality and Outcomes Framework (QOF) and an analysis tool, Reporting Analysis and Intelligence Delivering Results (RAIDR) to look at trends and compare performance with other practices. The practice had achieved an overall QOF score of 91.1% of the maximum points available in 2013/2014; this achievement was below both the local Clinical Commissioning Group (CCG) and the national averages (94.5% and 93.5% respectively). However, the practice told us their initial 2014/2015 QOF results showed an improvement in the overall score. For example, they had achieved all of the points available for dementia, whereas during 2013/2014 this score was only 85.9%. This confirmed the practice had delivered care and treatment in line with expected national standards.

QOF data for 2013/14 showed the practice participated in an external peer review with other practices in the same Clinical Commissioning Group (CCG), in order to compare data (peer review enables practices to access feedback from colleagues about how well they are performing against agreed standards). Regular checks of the practice disease registers were carried out to make sure patients received recommended levels of care and treatment.

Arrangements were in place which supported the identification, promotion and sharing of good practice. For example, a system was in place which ensured significant events were discussed within the practice team. Staff were encouraged and supported to learn lessons where patient outcomes were not of the standard the practice expected.

We found that staff felt comfortable to challenge existing arrangements and looked to continuously improve the service being offered.

Leadership, openness and transparency

There was a well-established management team with clear allocation of responsibilities. For example, one of the GPs was the lead for minor surgery, and another was the safeguarding lead. We spoke with staff from different teams; 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. Staff worked together and shared information. They told us the managers extended the same care to them as to the patients. Managers felt this had led to the practice having a loyal and long standing employee list.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the managers were visible and accessible. Records showed that regular meetings took place for all staff groups.

The practice manager told us that they met with the lead GP every morning and information from these meetings was shared with staff. Staff told us that the GPs, practice

Are services well-led?

Good

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

manager and team leaders were very supportive. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals.

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

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

The practice had made arrangements to seek and act on feedback from patients and staff. The practice manager told us they had been proactive in seeking feedback. There was a section on the website where patients could submit comments or feedback and there were suggestion boxes in the waiting rooms.

There was a virtual patient participation group (PPG) which was open to all patients. The practice manager told us they had made several attempts to encourage patients to have face-to-face meetings. Information about the PPG was on display in both waiting rooms. Until such a time when a meeting was arranged the practice manager had developed a virtual group; they shared ideas with patients and asked for their comments and suggestions via email.

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

We saw the practice had recently introduced the FFT, there were questionnaires available in the waiting rooms and instructions for patients on how to give feedback. The practice manager told us the comments and feedback was analysed monthly. The results were published within the practice and on their website. Initial results from January and February 2015 showed that 82% of patients said they would be extremely likely or likely to recommend this GP practice to their friends or family.

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

The practice had whistleblowing procedures and a detailed policy in place. Staff we spoke with were all able to explain how they would report any such concerns. They were all confident that concerns would be acted upon.

Management lead through learning and improvement

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

We saw that regular appraisals took place. Staff told us that the practice was supportive of training. They said they had received the training they needed, both to carry out their roles and responsibilities and to maintain their clinical and professional development. However, we found some staff had not completed training on infection control and fire safety.

All of the staff we spoke to said their personal development was encouraged and supported. Some staff were undertaking professional qualifications, for example a member of the administrative team was studying for a national vocational qualification (NVQ).

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

GPs met with colleagues at CCG meetings. They also attended learning events and shared information from these with the other GPs in the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met: Some information specified in Schedule 3 of the Health & Social Care Act 2008 in respect of people employed for the purposes of carrying on a regulated activity was not available.** **Regulation 19 (3) (a).**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met: Some staff had not received appropriate training to enable them to carry out the duties they were employed to do, including fire safety and infection control.** **Regulation 18 (2) (a).**