Dr Surendra Baliga

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

Summary of this inspection

Page

Overall summary 2
The five questions we ask and what we found 4
The six population groups and what we found 6
What people who use the service say 9
Areas for improvement 9
Outstanding practice 9

Detailed findings from this inspection

Our inspection team 10
Background to Dr Surendra Baliga 10
Why we carried out this inspection 10
How we carried out this inspection 10
Detailed findings 12

Overall summary

Letter from the Chief Inspector of General Practice

We carried out this comprehensive inspection on 19 May 2015.

Overall, we rated this practice as good. Specifically, we found the practice to be good for providing well-led, effective, caring, safe and responsive services.

Our key findings were as follows:

- The practice provided a good standard of care, led by current best practice guidelines.
- Patients told us they were treated with dignity and respect, and patient satisfaction levels were high.
- The practice performed well in the management of long term conditions, and was proactive in offering review and screening services.
- Patients could access appointments without difficulty, and were happy with the telephone and repeat prescribing systems.
- The building was safe for patients to access, with sufficient facilities and equipment to provide safe effective services.
- The practice had a caring, patient centred ethos and values, which staff were engaged with.

We saw several areas of outstanding practice including:

- The practice had gained an 'Investing in Children Award '. Membership is awarded to show that the practice where engaged in dialogue with children and young people, and this had resulted in change to help ensure that children and young people were treated with respect and dignity.
- The Nurse Practitioner had attended local schools along with the school nurse to promote services available for young people at the practice.
- The practice was proactive in identifying carers, including young carers. The practice had close links with a local carer charity, who had information displayed in reception. The charity also attended at flu clinics, to meet patients and identify carers.

Summary of findings

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

The provider should:

- Improve on structured minute taking for clinical and staff meetings.

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 roles and responsibilities in raising concerns, and reporting incidents. Lessons were learned from incidents, although some incidents within the practice had not been viewed as significant events, therefore there was some potential for under recording and learning opportunities to be missed. The practice had assessed risks to those using or working at the practice and kept these under review. There were sufficient emergency and contingency procedures in place to keep people safe. There were sufficient numbers of staff with an appropriate skill mix to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data from the Quality and Outcomes Framework (QOF) showed that the practice was performing highly in comparison to the Clinical Commissioning Group average. Guidance from the National Institute for Health and Care Excellence (NICE) was referred to routinely, and patient's needs were assessed and care planned in line with current legislation. This included promotion of good health and assessment of capacity where appropriate. Staff had received training appropriate to their roles. Clinical staff undertook audits of care and reflected on patient outcomes. The practice worked with other services to improve patient outcomes and shared information appropriately.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from patients about their care and treatment was consistently positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care. The practice was accessible. In patient surveys, the practice scored highly for satisfaction with their care and treatment, with patients saying they were treated with care and concern, although the practice was slightly below the local average for how patients felt involved in their treatment. The practice was proactive and working to identify carers, including young carers, and worked with a local carer's charity to help people access information and help.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had a good overview of the needs of their local population, and was proactive in engaging with the Clinical Commissioning

Summary of findings

Group (CCG) to secure service improvements. The practice had good facilities and was well equipped to meet patients need. Information was provided to help people make a complaint, and there was evidence of shared learning with staff. Patients told us they had no problems getting an appointment, with urgent appointments available the same day. The practice scored highly in patient surveys for how easy they found it to access appointments and get through on the phone.

Are services well-led?

Good

The practice is rated as good for being well-led. The staff team was small, cohesive and supportive. Staff were engaged with the culture and values of the practice, and described both the GP and practice manager as available and approachable. The practice had published values to work to with clear aims and objectives. There were systems in place to monitor quality and identify risk. The practice had an active Patient Participation Group (PPG) and was able to evidence where changes had been made as a result of PPG and staff feedback.

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. The practice held palliative care and multi-disciplinary meetings as required to discuss those with chronic conditions or approaching end of life care. Care plans had been produced for those patients deemed at most risk of an unplanned admission to hospital. Information was shared with other services, such as out of hours services and district nurses. Nationally returned data from the Quality and Outcomes Framework (QOF) showed the practice had good outcomes for conditions commonly found in older people. The over 75's had a named GP and opportunistic screening for the early signs of dementia was offered, for which there had been a high uptake rate.

The practice worked with Advanced Nurse Practitioners employed by the local Federation, who visited those in Nursing Homes and those who were recently discharged from hospital, to try to decrease hospital admissions.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. People with long term conditions were monitored and discussed at multi-disciplinary clinical meetings so the practice was able to respond to their changing needs. Information was made available to out of hours providers for those on end of life care to ensure appropriate care and support was offered. People with conditions such as diabetes and asthma attended regular nurse clinics to ensure their conditions were monitored, and were involved in making decisions about their care. Nurses communicated with the GP for each condition, although much of this was not recorded. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Attempts were made to contact non-attenders to ensure they had required routine health checks.

Families, children and young people

Outstanding

The practice is rated as outstanding for the care of families, children and young people. The practice had a dedicated teenage health area on the website, covering subjects such as puberty, drugs and alcohol, and healthy eating. The practice had worked with a group of young patients to improve services and gained the 'Investing in Children' award. The practice consulted with young people on health matters and how to improve existing services to make them

more accessible. The nurse practitioner had carried out joint visits with the school nurse to schools in the area to make young people aware of the services available at the practice and to help make them more confident in attending.

Systems were in place to identify children who may be at risk. The practice monitored levels of children's vaccinations and attendances at A&E. Immunisation rates were high for all standard childhood immunisations, and parents could attend at convenient times for these if they were unable to attend an immunisation clinic. Full post natal and 6 week baby checks were carried out by the GP. Patients could access community midwife clinics and drop in child health clinics run by the health visitor from the practice building.

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 population had been identified, and services adjusted and reviewed accordingly. Routine appointments could be booked in advance, or made online. Repeat prescriptions could be ordered online. Evening appointments were available one day a fortnight, and appointments were booked flexibly to enable workers to attend. Telephone appointments were available, and patients received a text reminder of the appointment.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people living in vulnerable circumstances. The practice had a register of those who may be vulnerable, including those with learning disabilities, who were offered annual health checks. Patients or their carers were able to request longer appointments if needed. The practice had a register for looked after or otherwise vulnerable children and also discussed any cases where there was potential risk or where people may become vulnerable. The computerised patient plans were used to flag up issues where a patient may be vulnerable or require extra support, for instance if they were a carer. Staff were aware of their responsibilities in reporting and documenting safeguarding concerns.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). National data showed the practice performed well in carrying out additional health checks and monitoring for those experiencing a mental

Summary of findings

health problem. For instance, 100% of patients with dementia had been given a care review within the last 12 months. 100% of patients with schizophrenia, bipolar affective disorder and other psychoses had an agreed care plan documented.

The practice made referrals to other local mental health services as required, and some counselling services could be accessed from the same site, providing easy access for patients.

Summary of findings

What people who use the service say

In the latest NHS England GP Patient Survey of 107 responses, 97% of patients reported their overall experience as good or very good. 84% said the GP was good at involving them in decisions about their care, while 88% said their GP was good or very good at treating them with care and concern. 100% said the last nurse they saw was good at listening to them. These results were all above the Clinical Commissioning Group (CCG) average.

Patients were satisfied with the appointments system. 97% of patients said it was easy to get through on the phone, 95% said were fairly or very satisfied with GP opening hours, and 95% described their experience of making an appointment as good. Again, these results were above average.

Results which were slightly below average included 81% of patients who said the last GP they saw or spoke to was good at listening to them, and 82% of patients who said the last GP they saw or spoke to was good at explaining tests and treatments.

We spoke to a member of the Patient Participation Group (PPG) and four patients as part of the inspection. We also collected 16 CQC comment cards which were sent to the practice before the inspection, for patients to complete.

All the patients we spoke to and the comment cards indicated they were satisfied with the service provided. Patients said they were treated with dignity and respect, and that staff were friendly and caring. Patients said that the telephones were always answered quickly, and that they did not struggle to get an appointment. Patients said they were confident with the care provided, and were treated as individuals.

Areas for improvement

Action the service SHOULD take to improve

- Improve on structured minute taking for clinical and staff meetings

Outstanding practice

- The practice had gained an 'Investing in Children Award '. Membership is awarded to show that the practice where engaged in dialogue with children and young people, and this had resulted in change to help ensure that children and young people were treated with respect and dignity.
- The Nurse Practitioner had attended local schools along with the school nurse to promote services available for young people at the practice.
- The practice was proactive in identifying carers, including young carers. The practice had close links with a local carer charity, who had information displayed in reception. The charity also attended at flu clinics, to meet patients and identify carers.

Dr Surendra Baliga

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 specialist advisor GP, and a Practice Manager.

Background to Dr Surendra Baliga

Dr Surendra Baliga is a sole GP, providing primary medical services (PMS) to approximately 1,400 patients in the catchment area of Shildon, which is the Durham Dales, Easington and Sedgefield Clinical Commissioning Group (CCG) area.

There is one GP, who is male, although it is possible for patients to request a female GP, who would attend from another practice under a sharing agreement. There is one nurse practitioner and one practice nurse, both of whom are female. These are supported by a practice manager, two reception and administrative staff, and a trainee.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures; family planning; surgical procedure, maternity and midwifery services; and treatment of disease, disorder and injury. The practice has higher levels of deprivation compared to the England average. There are higher levels of people with a long term health condition, or with caring responsibilities, and lower levels of employment.

The practice has opted out of providing Out of Hours services, which patients access through the 111 service. The practice is a member of the South Durham Health CIC Federation.

Why we carried out this inspection

We carried out the inspection 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 CQC at that time.

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

Detailed findings

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. We also spoke with a member of the Patient Participation Group.

We carried out an announced inspection on 19 May 2015.

We reviewed all areas of the surgery, including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with the practice manager, GP, nursing staff, and administrative and reception staff.

We observed how staff handled patient information received from the out-of-hour's team and patients ringing the practice. We reviewed how The GP made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included reported incidents, national patient safety alerts, and complaints, some of which were then investigated as significant events. Prior to inspection the practice gave us a summary of significant events from the previous 12 months.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff and the GP we spoke to were aware of incident reporting procedures. They knew how to access the forms, and felt encouraged to report incidents. The practice worked with the Clinical Commissioning Group (CCG) in reporting incidents as necessary.

The practice had systems in place to record and circulate safety and medication alerts received into the practice. From our discussions we found the GP and nurses were aware of the latest best practice guidelines and incorporated this into their day-to-day practice.

Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed the practice was appropriately identifying and reporting significant events.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the previous year. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

We saw where incidents had been discussed and reviewed, and learning points documented. We saw where actions had been taken as a result, such as communications with other healthcare providers, and sharing information with the CCG. We did discuss with the practice that there was potential for under recording of incidents, with some incidents within the practice not being viewed as significant events.

Significant events were discussed as part of practice meetings, although the last practice meeting which had minutes produced was from February 2015. Significant events were not a standing item on the practice meeting agenda, with much of the communication coming from an informal morning meeting for half an hour each day. While staff said they were informed of the outcome of significant events investigations, it was difficult to evidence that all opportunities for learning had been taken.

We could see from a summary of significant events and complaints that where necessary the practice had communicated with patients affected to offer a full explanation and apology, and told what actions would be taken as a result, or told why a request could not be actioned.

National patient safety alerts were disseminated by email or via the intranet. Staff were able to give recent examples of alerts relevant to them and how they had actioned them, such as a recall of equipment or changes to medication guidance.

Reliable safety systems and processes including safeguarding

The practice had up to date CCG child protection and vulnerable adult policies and procedures in place. These contained contact details for organisations such as social services and the police. Staff knew how to access the policies. The GP was the named safeguarding lead with the practice manager as deputy. Staff said they felt confident in following a flowchart for the procedure and would report incidents to either the GP or the practice manager.

Regular multi-disciplinary safeguarding meetings were held, quarterly or as required. These were attended by health visitors and school nurses, to discuss children who were potentially at risk or on a Child Protection Plan. These other professionals worked from the same building so the practice had been able to develop close working relationships, which allowed quick access to advice and onward referral when needed.

Procedures provided staff with information about identifying, reporting and dealing with suspected abuse. Staff knew how to access these. Staff were able to described types of abuse and how to report these. Staff had been trained in safeguarding at a level appropriate to their role.

The computerised patient plans were used to enter codes for children on the at risk register. The practice had systems

to monitor children who failed to attend for childhood immunisations, or who had high levels of attendances at A&E. Information was passed to the health visitor as appropriate.

The practice had a chaperone policy, and there was information on this service for patients in reception, although not in the practice leaflet. Staff were able to explain their role in acting as a chaperone.

Medicines Management

We checked medicines in the treatment rooms and found they were stored securely and were only accessible to authorised staff. We checked medicines in the fridges and found these were stored appropriately. Daily checks took place to make sure refrigerated medicines were kept at the correct temperature, and thermometers were calibrated yearly. Dedicated members of staff were responsible for ordering, stock checking and cold chain procedure. There was a process for checking that refrigerated and emergency medicines were within their expiry dates, although we did find one item out of date.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice had a repeat prescribing protocol, with processes to check the issue of repeat prescriptions, medication reviews and lost or uncollected prescriptions. The practice reviewed its prescribing data through clinical audits and communication with the CCG, and had audited, for example, antibiotic use.

Prescriptions were stored securely, and there was a system in place for the GP' to double check repeat prescriptions before they were generated. There was a process to regularly review patients' repeat prescriptions to ensure they were still appropriate and necessary. Any changes in medication guidance were communicated to clinical staff. This helped to ensure staff were aware of any changes and patients received the best treatment for their condition.

Cleanliness & Infection Control

Patients we spoke with told us they found the practice to be clean and had no concerns about cleanliness. The practice had infection prevention and control (IPC) and waste disposal policies, and these were reviewed and updated regularly. There was an identified IPC lead, and an infection control audit had recently been carried out. We saw that cleaning schedules for all areas of the practice were in place, with daily, monthly and six monthly tasks. The practice had recognised that these lists were not previously audited to ensure that all tasks had been carried out, so had instigated new checks to ensure ongoing cleanliness between a full yearly infection-control audit.

We saw evidence that staff had training in IPC to ensure they were up to date in all relevant areas. Aprons, gloves and other personal protective equipment (PPE) were available in all treatment areas.

Sharps bins were appropriately located, labelled, closed and stored after use. A legionella risk assessment had been carried out.

Staff said they were given sufficient PPE to allow then to do their jobs safely, and were able to discuss their responsibilities for cleaning and reporting any issues. Staff we spoke with told us that all equipment used for invasive procedures and for minor surgery were disposable. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We saw other equipment such as blood pressure monitors used in the practice was clean.

We saw evidence that staff had their immunisation status for Hepatitis B checked which meant the risk of staff transmitting infection to patients was reduced. They told us how they would respond to needle stick injuries and blood or body fluid spillages and this met with current guidance.

Equipment

We found that equipment such as spirometers, ECG machines (used to detect heart rhythms) and fridges were checked and calibrated yearly by an external company.

Contracts were in place for checks of equipment such as fire extinguishers and fire alarms, and portable appliance testing had been carried out. Review dates for all equipment were overseen by the practice manager. We did find that the emergency oxygen cylinder had not been serviced within the manufacturer's guidelines, although on checking it was full and operational. Staff had been carrying out visual checks on the cylinder but had overseen the date. The practice took corrective action by having a new cylinder delivered the week after the inspection, and signing up to a new servicing agreement with the provider.

Good

Are services safe?

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Staff told us they were trained and knowledgeable in the use of equipment for their daily jobs, and knew how to report faults with equipment.

Staffing & Recruitment

Staff files we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Some staff operated in dual roles, for instance administration/reception, therefore this allowed some flexibility in cover and planning. Staff said they had a multi-skilled team who supported each other, and that the practice ran well. There were arrangements in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Nursing staff said they could cover each other's work, work extended hours, or access another nurse practitioner who is employed on behalf of the Federation. GP holiday was covered by another GP from a different practice who the GP worked in partnership with.

Monitoring Safety & Responding to Risk

We found that staff recognised changing risks within the service, either for patients using the service or for staff, and were able to respond appropriately. There were procedures in place to assess, manage and mainly monitor risks to patient and staff safety. These included annual, monthly and weekly checks and risk assessments of the building, the environment and equipment, and medicines management, so patients using the service were not exposed to undue risk.

There were health and safety policies in place covering subjects such as fire safety, manual handling and equipment, and risk assessments for the running of the practice. These were all kept under review to monitor changing risk. An annual health and safety assessment was carried out.

Patients with a change in their condition or new diagnosis were reviewed appropriately and discussed at clinical meetings, which allowed clinicians to monitor treatment and adjust according to risk, although practice clinical meetings were not minuted. Information on patients was made available electronically to out of hours providers where necessary so they would be aware of changing risk.

Arrangements to deal with emergencies and major incidents

Staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. We saw records confirming staff had received Cardio Pulmonary Resuscitation training. There was a defibrillator available which was checked and serviced regularly. Staff who used the defibrillator were regularly trained to ensure they remained competent in its use. This helped to ensure they could respond appropriately if patients experienced a cardiac arrest.

Staff described the roles of accountability in the practice and what actions they needed to take if an incident or concern arose, including how to summon for assistance.

A business continuity plan and emergency procedures were in place which had been recently updated, which included details of scenarios they may be needed in, such as loss of data or utilities. Weekly fire alarm checks took place and fire drills every six months.

Emergency medicines, such as for the treatment of cardiac arrest and anaphylaxis, were available and staff knew their location.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All clinical staff we interviewed were able to describe how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. They were able to demonstrate how these were received into their practice and disseminated via the computer system as assigned tasks, or via email.

Treatment was considered in line with evidence based best practice. Clinical staff we' interviewed were aware of their professional responsibilities to maintain their knowledge. Nursing staff implemented long-term condition clinics flexibly, with patients able to attend a longer appointment to discuss multiple needs. The nurses attended regular updates and implemented changes as appropriate to ensure best practice. The nurses were supported by the GP and attended clinical meetings.

The practice kept up to date disease registers for patients with long term conditions such as asthma, diabetes and chronic heart disease which were used to arrange annual, or as required, health reviews. The practice was proactive in screening patients for long-term conditions, for instance patient reminder markers were used on the clinical system to identify patient specific needs, such as eligibility for early dementia screening.

Staff were able to demonstrate how care was planned to meet identified needs using best practice templates which were kept under review, and how patients were reviewed at required intervals to ensure their treatment remained effective. For instance, diabetes indicators on the QOF (2013-14) were above the national average. The percentage of patients with diabetes on the register, whose last blood pressure reading was below a target level was 100%. The national average was 78.6%. 100% of patients with dementia had been given a care review within the last 12 months. The practice had a culture of placing patients at the centre of decision making about their own care and encouraging self-management of long-term conditions.

They also provided annual reviews to check the health of patients with learning disabilities and mental illness. The practice could produce a list of those who were in need of palliative care and support, and held end of life planning discussions. Patients requiring palliative care or with new cancer diagnosis were discussed at regular multi-disciplinary care meetings to ensure their needs assessment remained up to date.

Patients with long term conditions such as diabetes had regular health checks, and were referred to other services or discussed at multi-disciplinary meetings when required. National standards for referral were used, for instance two weeks for patients with suspected cancer to be referred and seen.

The practice, in conjunction with an Advanced Nurse Practitioner (ANP) employed by the Federation, had identified their 2% of most vulnerable patients, who were at risk of an unplanned admission to hospital, and had produced enhanced care plans for these. These were regularly reviewed and discussed, for instance after an admission, to ensure they were accurate and addressed the needs of those patients. Regular ward rounds were carried out in two local nursing homes by both the ANP and GP to ensure the needs assessment of vulnerable patients remained up to date.

We saw no evidence of discrimination when making care or treatment choices, with patients referred on need alone.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients care and outcomes. It used the Quality and Outcome Framework (QOF) to assess its performance and undertook clinical audits. QOF data from 2013-14 showed the practice had an overall rating of 100%.

The practice had high levels of some long-term conditions, such as chronic obstructive pulmonary disease (COPD) and heart disease. The practice had a good understanding of the needs of the local population. They were proactive in monitoring outcomes for these patients to improve care, for instance ensuring a same-day appointment was available for a patient with COPD exacerbation to help reduce avoidable attendances at A&E.

Clinical staff were proactive in checking the clinical system to ensure that routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up when patients needed to attend for a medication review before a repeat prescription was issued.

Good

Are services effective?

(for example, treatment is effective)

The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved, however much of this was informal and not recorded.

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. For instance the practice looked at prescribing data and compared these against criteria, then looked to see how patient outcomes could be improved.

The GP told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). The practice carried out some clinical audits, examples of which included antibiotic prescribing and wound infection rates after minor surgery. The practice said they did not carry out a full regular clinical audit program due to the small number of patients meaning the results would not be statistically significant. However consideration could have been given to alternative methods, for instance more qualitative monitoring.

Effective staffing

The practice manager oversaw a computerised training matrix which showed when essential training was due. We saw that the mandatory training for clinical staff included safeguarding and infection control. Staff had access to additional training related to their role. Staff were encouraged to identify learning and development needs which would assist them in their role and benefit the practice.

We saw evidence that the GP had undertaken annual external appraisals and had been revalidated, an assessment to ensure they remain fit to practice. Continuing Professional Development for nurses was monitored as part of the appraisals process, and professional qualifications were checked yearly to ensure clinical staff remained fit to practice.

We saw evidence that clinical and non-clinical staff had yearly appraisals, which identified individual learning needs and action points from these. Nursing staff said they were able to meet with the GP regularly, for clinical supervision and best practice discussions, although much of this was informal and not recorded. Nursing staff were able to access protected learning time (PLT) every other month through the CCG were a variety of clinical topics were discussed. Nursing staff did tell us that they did not have the opportunity to have clinical discussions with nurses at other practices as part of a best practice information sharing forum.

On starting, staff commenced an induction comprising subjects such as health and safety, incident reporting and fire precautions, in addition to further role specific induction training and shadowing of other members of staff. An induction progress interview could be held at the end of each completed month of employment to a maximum of three interviews.

Staff said they felt confident in their roles and responsibilities, and were encouraged to ask for help and support. They gave examples of when they had asked, for instance, a GP or nurse for additional clinical support if they felt unsure.

Working with colleagues and other services

Regular multi-disciplinary meetings were held with district nurses, health visitor, Macmillan nurses and clinical staff to identify and discuss the needs of those requiring palliative care, or safeguarding issues. An Advanced Nurse Practitioner (ANP) employed by the local area Federation visited patients in nursing homes daily, and the GP visited weekly. The GP told us there was ongoing communication between the practice, the ANP and district nurses to review the care planning and needs of vulnerable patients.

Many services such as the health visitor, smoking cessation and physiotherapy were located within the same building, meaning the practice could communicate easily. The practice told us this helped patients get easy access to appointments.

The practice had gained an ‘Investing in Children Award '. Investing in Children has a 'Membership Scheme' that acknowledges and celebrates examples where children and young people are treated with respect and dignity. Membership is awarded to show that the people working there are engaged in dialogue with children and young people, and this has resulted in change. One example of this is that the Nurse Practitioner had attended local schools along with the school nurse to promote services available for young people at the practice.

Regular clinical and non-clinical staff meetings took place, although the practice had identified as an area they would like to improve the frequency of whole practice meetings.

Good

Are services effective?

(for example, treatment is effective)

Staff described communication in the practice is generally good. The practice manager was able to meet with other managers in the area on a monthly basis, to share best practice.

The practice worked with the nearby Carer's centre to identify and give information to carers, through information in reception and also encouraging the centre to attend at flu clinics to reach a wider audience. The practice signposted or made direct referrals to local drug and alcohol services where required.

Blood results, discharge letters and information from out of hours providers was generally received electronically and disseminated straight to the relevant member of clinical staff , or where necessary a procedure for scanning documents was in place. The GP recorded their actions around results or arranged to see the patient as clinically necessary.

Information Sharing

Staff said that due to the practice's small size, communication and information sharing was generally good. Much information sharing was informal and on a daily basis. Clinical staff said they could meet with the GP each day, and nonclinical staff received ongoing updates and communication from the practice manager. The practice manager said they struggled to meet as a whole group, as the time available for this was during CCG protected time, when the GP and practice manager had to attend at meetings. The practice was looking at ways to improve this.

Information on unplanned admission was collated from multi-disciplinary meetings and fed back to the CCG to identify themes and trends.

Referrals were made using the Choose and Book system which was completed where possible at the time of GP consultation. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

There was a shared system with the out of hours provider to enable information to be shared in a timely manner and as appropriate. The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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. The practice aimed to enter patient information such as records of home visits and hospital letters onto the system the same day.

Consent to care and treatment

We found that staff were able to describe how they would deal with issues around consent. For instance, GPs and nursing staff explained examples where people had recorded advance decisions about their care or their wish not to be resuscitated. Where those with a learning disability or other mental health problems were supported to make decisions, this was recorded.

We did find that staff had not been given specific training around the Mental Capacity Act 2005. Staff described consent issues as being covered in other training modules, such as safeguarding. However staff were confident in discussing how they would deal with consent issues, including how they would involve parents and carers.

There was a practice policy on consent to support staff and staff knew how to access this, and were able to provide examples of how they would deal with a situation if someone did not have capacity to give consent, including escalating this for further advice to a senior member of staff where necessary.

Verbal consent was documented on the computer as part of a consultation, and staff were able to explain how they would discuss a procedure, detailing risks and benefits. Written consent forms were used for invasive procedures such as ear syringing or coil fitting, which detailed risks, benefits and potential complications, this allowed patients to make an informed choice.

Health Promotion & Prevention

The practice offered all new patients an assessment of past medical history, care needs and assessment of risk. Advice was given on smoking, alcohol consumption and weight management. Smoking status was recorded and patients were offered advice or referral to a cessation service. There was a culture among clinical staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers, or screening for the early signs

Good

Are services effective?

(for example, treatment is effective)

of dementia. Carers were offered health checks. The practice had a high uptake of new patient health checks and screening checks, and sought to involve the patient in self-management of long-term conditions.

Nurses used chronic disease management clinics where patients were seen for multiple conditions to promote healthy living and ill-health prevention. Patients over the age of 75 had been allocated a named GP.

The practice had a dedicated teenage health leaflet available on the website, covering subjects such as puberty, drugs and alcohol, and healthy eating. In recognition of the difficulties young people can experience in accessing health services, the practice had worked with a group of young patients to improve services and gained the 'Investing in Children' award. The practice consulted with young people on health matters and how to improve existing services to make them more friendly and accessible. The Nurse Practitioner visited the local Secondary and Primary School with the School Nurse to allow the children to feel at ease with Health Professionals. Services Provided included mental health assessments for young people, support for young carers, and access to Chlamydia screening.

Patients aged 40-75 were offered a health check in line with national policy, to help detect early risks and signs of some conditions such as heart disease and diabetes. The practice had access to an on-site dietician, physiotherapy services, and counsellors, which aided referrals and was convenient for patients.

The practice's performance for cervical smear uptake and flu vaccinations was comparable to the CCG and England average. There was a policy to follow up patients who did not attend for cervical smears and the practice audited rates for patients who did not attend.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

In the latest NHS England GP Patient Survey of 107 responses, 97% of patients reported their overall experience as good or very good. 84% said the GP was good at involving them in decisions about their care, while 88% said their GP was good or very good at treating them with care and concern. 100% said the last nurse they saw was good at listening to them. These results were all above the Clinical Commissioning Group (CCG) average.

We spoke to a member of the Patient Participation Group (PPG) and four patients as part of the inspection. We also collected 16 CQC comment cards which were sent to the practice before the inspection, for patients to complete.

All the patients we spoke to and the comment cards indicated they were satisfied with the service provided. Patients said they were treated with dignity and respect, and that staff were friendly and caring. Patients said they were confident with the care provided, and were treated as individuals. Some patients gave specific examples of where they had been impressed by the level of care and kindness demonstrated by the doctor and all staff.

All the staff we spoke with told us of the caring culture within the practice. It was common for multiple generations of the same families to attend at the practice for many years, and staff knew the patients well. Our observations confirmed that reception staff were friendly and polite when treating patients, and often knew patients by their first names.

The practice phones were located away from the reception desk which helped keep patient information private. There was a room available where patients could request to speak with a receptionist in private if necessary. We observed that reception staff maintained confidentiality as far as possible. The practice survey indicated that a number of patients said they could be overheard at reception. The practice had previously tried to address this, including redesigning the reception desk, playing music so that patients could not be overheard, and creating an area for patients to stand away from the desk. The practice action plan indicated they would still discuss this with the PPG to explore further solutions. We did not receive complaints about this at the time of inspection.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were used in treatment and consulting rooms to maintain patients' privacy and dignity during investigations and examinations. There was a chaperone policy and guidelines for staff, and information available on this in reception. Nursing staff acted as chaperones where requested, and other non-clinical staff had also been trained.

Care planning and involvement in decisions about care and treatment

In the latest NHS England GP Patient Survey of 107 responses, 84% said the GP was good at involving them in decisions about their care, which was above the CCG average. Results which were slightly below average included 81% of patients who said the last GP they saw or spoke to was good at listening to them, and 82% of patients who said the last GP they saw or spoke to was good at explaining tests and treatments.

The templates used on the computer system for people with long term conditions supported staff in helping to involve people in their care. Nursing staff provided examples of where they had discussed care planning and supported patients to make choices about their treatment. Extra time was given during appointments where possible to allow for this, and multiple conditions could be discussed in one lengthened appointment.

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

In the latest practice survey, 42 out of 46 responses said the practice was good at helping patients understand their health problems. Patients said the GP explained treatment and results in a way they could understand, and they felt able to ask questions, and felt sufficiently involved in making decisions about their care.

Staff told us there was a translation service available for those whose first language was not English.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

Patients said they were given good emotional support by the doctor, and were supported to access support service to help them manage their treatment and care. Comment cards filled in by patients said the doctor and nurses provided a caring empathetic service. In the latest practice survey, 45 out of 60 respondents said they were given good support to cope with their treatment.

When patients had suffered bereavement, the GP said he made sure he saw this patient, and if necessary arranged referral to a bereavement counselling service.

The practice kept registers of groups who needed extra support, such as those receiving palliative care and their carers, and patients with mental health issues, so extra support could be provided. The practice was proactive in identifying carers, including young carers. The practice worked with a local carer charity, who had information displayed in reception. The charity also attended at flu clinics, to meet patients and identify carers.

For patients in need of mental health support, the practice referred to the Primary Care Mental Health service. Some of these counselling appointments were held on site, enabling patients to access them easily. The practice also referred to other locally specific services for mental health issues. The practice carried out postnatal depression screening.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were well understood and systems were in place to address identified needs.

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. These were led by CCG targets for the local area, and the practice worked closely with the CCG to discuss local needs and priorities. Longer appointments were made available for those with complex needs. Review appointments were often made by the GP at the time of consultation to enable continuity of care.

The practice was proactive in monitoring those who did not attend for screening or long term condition clinics, and made efforts to follow them up. The facilities and premises were appropriate for the services which were planned and delivered, with sufficient treatment rooms and equipment available.

Home visits and telephone appointments were available where necessary.

Tackling inequity and promoting equality

The building, owned by the NHS trust, accommodated the needs of people with disabilities, incorporating features such as level access, automatic doors and level thresholds. Treatment and consulting rooms were on the ground floors. A number of disabled parking spaces were available in the car park outside. We saw the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

There was a practice information leaflet available. However patients had to request these from reception. It covered subjects such as services available, out of hours services, access to records and directions to the practice website. There was a hearing loop at reception to assist those hard of hearing.

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to translation services were available if needed. Patient records were coded to flag to the GP when someone was living in vulnerable circumstances or at risk. The GP was on the panel for Durham Constabulary as part of their Equality and Diversity group. Staff had carried out Equality, Diversity and Human Rights training.

Access to the service

Information was available to patients about appointments on the practice website and patient information leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed.

Appointments could be made in person, by telephone or online. Repeat prescriptions could be also be ordered online. Patients could generally access an appointment to the same day. Pre-bookable appointments were also available.

Telephone lines were open from 8:00am until 6:00pm Monday to Friday. Actual consulting times were between 9:30am - 11:00am and 3:00pm - 5:30pm. Late appointments were available on a Tuesday evening every other week from 6.30pm - 8.00pm. These were pre-bookable appointments. Opening times and closures were advertised on the practice website, with an explanation of what staff provided which services. Longer appointments were also available for patients who needed them and those with long-term conditions. Home visits were made to two local nursing homes each week, and home visits were made as required.

Patients we spoke to told us they could access appointments without difficulty. In the latest NHS England GP Patient Survey of 107 responses 97% said it was easy to get through on the phone, and 95% of patients said were fairly or very satisfied with GP opening hours. These results were both well above the national average. These results were the same in the latest practice survey where 100% of respondents said it was fairly or very easy to get through on the phone.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 GP's in England and there was a designated responsible person who handled all complaints in the practice. Information on how to complain was contained in the patient information leaflet, and staff were able to signpost people to this.

We looked at a summary of complaints made during 2014, and could see that these had been responded to with an explanation and apology. The practice carried out a patient survey in 2014-15. An action plan was then drawn up and agreed with the PPG. Examples of actions included further promotion of online services and a change to telephone triage systems, although these did not include a date for completion. Results of this survey were available on the practice website. There was a box in reception where patients could leave feedback through the 'Friends and Family' test, and this feedback was monitored.

Patients we spoke with said they would feel comfortable raising a complaint if the need arose. The practice survey indicated that the majority of patients understood how to use the complaints procedure.

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 clear aims and objectives to provide equitable and quality health care services, contained in their statement of purpose. The practice had a philosophy of patient centred care. The practice had a four-year forward plan, which included succession planning, service continuity and awareness of opportunities and issues for the future.

Staff were familiar in and engaged with the values and ethos of the practice, and stressed the importance of good relationships with the patients. The staff team was described as small, friendly and close-knit.

Staff had individual objectives via their appraisal which fed in to these, such as clinical staff looking to develop their knowledge in a certain area to be able to offer additional service.

Governance Arrangements

Staff were clear on their roles and responsibilities, and felt able to communicate with the doctor or manager if they were asked to do something they felt they were not competent in. The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared computer system. All the policies and procedures we looked at, such as chaperone policy, Mental Capacity Act policy and human resources policies had been reviewed and were up to date. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff within the practice.

The practice used the Quality and Outcomes Framework (QOF) to measure performance. The QOF data for this practice showed it was performing above national standards. The practice regularly reviewed its results and how to improve, and was proactive in using patient contact to promote additional screening or review services. From our discussions with staff we found that they looked to continuously improve the service being offered, and valued the learning culture. We saw evidence that they used data from various sources including incidents, complaints and audits to identify areas where improvements could be made, such as a template to review antibiotic prescribing.

The practice had some identified lead roles, such as for safeguarding, prescribing, chronic disease management and infection control. Some clinical audit was carried out, subjects selected from QOF outcomes, from the CCG, following an incident or from the GP's own reflection of practice. The practice had stated they struggled to find subjects with statistically significant numbers of patients to study, although further consideration could have been given to alternative options, such as more qualitative studies.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us a checklist for potential risks and health and safety assessments which addressed a wide range of health, safety and welfare issues, such as legionnaires risk assessment or recruitment checks for staff.

Leadership, openness and transparency

Staff said they felt happy to work at the surgery, and described the culture as friendly, open and supportive. Staff said they were supported to deliver a good service and good standard of care, and that both the GP and practice manager were available and approachable. Staff felt confident in raising concerns or feedback.

Staff described communication as generally good, although the practice had identified that they wished more opportunity for full practice meetings. Much communication throughout the practice was informal and ongoing, rather than structured minuted meetings. The recording of these meetings had been identified as an area for improvement.

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

There was an active Patient Participation Group (PPG), which met every eight weeks. The practice was actively advertising to recruit to the group to ensure it was representative of the practice population. Patients could also participate in the group via e-mail. Patients were encouraged to participate in the Friends and Family Survey via reception and the practice newsletter. Members could also meet with other groups throughout the CCG area. A PPG representative told us that the practice manager asked them for feedback and that they actively worked in partnership together.

Are services well-led?

Good

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

We saw from minutes that the practice discussed with the PPG patient survey reports and produced action plans and reviews from these. These were published on the practice website. Examples of actions included further promotion of online services and a change to telephone triage systems, although these did not include a date for completion.

Staff told us they felt confident giving feedback. Staff stated they generally felt involved and engaged in the practice to improve outcomes for both staff and patients. There was a whistleblowing policy which was available to all staff.

Management lead through learning & improvement

We saw that appraisals and induction progress interviews took place where staff could identify learning objectives and training needs, and raise any concerns. The practice had recently introduced a monthly staff reflection form, with the intention that staff could take time out to reflect on how the month had gone, and this would then be discussed at staff meetings to support learning and improvement.

The practice had completed reviews of significant events and other incidents. Staff told us the culture at the practice was one of continuous learning and improvement, and was supporting a trainee at the time of inspection. Staff said they welcomed feedback from other sources, such as midwifes and advanced nurse practitioners, as they were aware of the risk of working in isolation in a small practice.

Nursing staff and the GP were able to access protected learning time (PLT) every other month through the CCG were a variety of clinical topics were discussed. Nursing staff did tell us that they did not have the opportunity to have clinical discussions with nurses at other practices, and would welcome the opportunity for further clinical supervision.