Bewick Crescent Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out this comprehensive inspection on 10 September 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.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice actively reviewed their performance in the management of long term conditions, and was proactive in offering review and screening services.
- The practice actively sought to make improvements following feedback from patients and patient groups.
- The building had sufficient facilities and equipment to provide safe effective services.
- There was a clear leadership structure and staff felt supported by management.
- Nursing staff were given additional protected learning time each week for professional development. Staff were highly supported within their roles to develop their interest in new specialist areas and obtain further qualifications.
- The practice had good retention rates for GPs, with seven out of the 10 GPs having previously been in training at the practice.

Summary of findings

- The practice Healthcare Assistants (HCA) had received an award from the County Durham NHS stop smoking service for high quit rates achieved

We saw several areas of outstanding practice:

- Following a project initiated by the practice, community psychiatric nurses were employed and managed at the practice on behalf of the Federation as an additional suicide prevention service. Patients referred to the service would be given an hour-long appointment within two days at any one of three practices within the area.
- Learning disability patients were given a 'health action plan', which was an easy read summary of their health checks, which they could then take away with them and bring to the next appointment.
- People with a new diagnosis of diabetes were invited to monthly group education events, attended by among others GPs, nurses, and dieticians. The medical secretary responsible for referrals and arrangement of treatment also attended, so that patients could meet a named point of contact within the system.

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

The provider should:

- Ensure that stock control and date check systems function correctly so that all single use clinical instruments stored and used are within their expiry dates. Dispose of in accordance with the appropriate guidance any unused instruments or equipment which have expired.

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, and we found evidence that incidents had been reported, discussed and reflected upon. 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) from 2013-14 showed that the practice performed near to the Clinical Commissioning Group average. Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. The practice had identified areas they wished to improve following clinical audit and had implemented changes to facilitate this. The practice was proactive in promotion of good health and patient involvement. Initiatives included re-introducing physical new patient health checks, a health action plan for learning disability patients and the highest quit rate in the area at 12 weeks for the smoking cessation services. Staff were highly supported within their roles to develop their interest in new specialist areas and obtain further qualifications. The practice had good retention rates for GPs, with seven out of the 10 GPs having previously been in training at the practice.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from patients about their care and treatment was positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care. In patient surveys, the practice scores were around average compared to local and national survey results. Patients said they were treated with care and concern.

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 Group (CCG) to secure service improvements. In response to a local

Summary of findings

need, the practice had initiated a local suicide prevention project. The practice had good facilities and was well equipped to meet patients need. Information was provided to help patients make a complaint, and there was evidence of shared learning with staff. The practice scored highly in patient surveys for how quickly patients got seen after their appointment time, and how satisfied patients were with the opening hours. Patients were less satisfied with how easy it was to see the GP of their choice.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a forward plan 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. Staff described the management team as available and approachable, and said they felt highly supported in their roles. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk.

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 regularly 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.

The practice worked with attached advanced nurse practitioners employed by the local Federation, who carried out daily 'ward rounds' in nursing homes, in conjunction with the named GP contact. The practice participated in the unplanned admissions scheme, which aimed to help decrease hospital admissions for the elderly. All emergency admissions were reviewed within 24 hours of receipt of discharge information.

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 for and discussed at multi-disciplinary clinical meetings so the practice was able to respond to their changing needs. Outcomes were monitored through clinical audits. 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 attended regular clinics to ensure their conditions were monitored, and were involved in making decisions about their care. The practice was proactive and innovative in the management of long-term conditions, such as holding group education events for new diabetic patients, attended by all staff who patients were likely to come into contact with. Nurses communicated with GPs for each condition. Attempts were made to contact non-attenders to ensure they had appropriate routine health checks.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. 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. Regular multidisciplinary meetings were held to review children on the safeguarding register. Immunisation rates were around the average for all standard childhood

immunisations. Midwives ran antenatal clinics jointly with the GPs on a weekly basis. After birth, both mothers and babies were seen by GPs at eight weeks for checks, alongside with nurse-led immunisation clinics held at the practice. These clinics were held at convenient times before school ended, helping parents with school age children.

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. Walk-in clinics were also available at the branch surgery. Repeat prescriptions could be ordered online. Telephone appointments were available, and patients received a text reminder of the appointment. Saturday morning appointments were available weekly via 111 or for those patients who could not access the surgery at any other time. The practice carried out health checks for people of working age, and actively promoted screening programmes such as for cervical cancer.

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). The practice made referrals to other local mental health services as required. QOF data showed in 2013-14 the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 93%, above the national average of 86.04%. The practice carried out opportunistic screening for dementia. The practice employed and managed on behalf of the

Summary of findings

Federation community psychiatric nurses as an additional suicide prevention service. Patients referred to the service would be given an hour-long appointment within two days at any one of three practices within the Newton Aycliffe area.	

Summary of findings

What people who use the service say

The latest NHS England GP Patient Survey of 112 responses showed the following:

What this practice does best

76% of respondents usually wait 15 minutes or less after their appointment time to be seen

Local (CCG) average: 70% National average: 65%

84% of respondents are satisfied with the surgery's opening hours

Local (CCG) average: 81% National average: 75%

94% of respondents describe their overall experience of this surgery as good

Local (CCG) average: 91% National average: 85%

What this practice could improve

53% of respondents with a preferred GP usually get to see or speak to that GP

Local (CCG) average: 62% National average: 60%

75% of respondents find it easy to get through to this surgery by phone

Local (CCG) average: 80% National average: 73%

91% of respondents say the last appointment they got was convenient

Local (CCG) average: 94% National average: 92%

We spoke with two members of the Patient Participation Group (PPG) and five patients as part of the inspection. We also collected 66 CQC comment cards which were sent to the practice before the inspection, for patients to complete.

Almost all patient feedback and comment cards indicated patients they happy with the service provided. Patients said they were treated with dignity and respect, and given sufficient time during appointments. Staff were pleasant and friendly. Patients said that the facilities at the practice were good, and that they had good access to same day and pre-bookable appointments. Patients said they were confident with the care provided, and were involved in their treatment options.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that stock control and date check systems function correctly so that all clinical instruments and equipment are used within their expiry dates. Dispose of in accordance with the appropriate guidance any unused instruments or equipment which have expired.

Outstanding practice

- Following a project initiated by the practice, community psychiatric nurses were employed and managed at the practice on behalf of the Federation as an additional suicide prevention service. Patients referred to the service would be given an hour-long appointment within two days at any one of three practices within the area.
- Learning disability patients were given a 'health action plan', which was an easy read summary of their health checks, which they could then take away with them and bring to the next appointment.
- People with a new diagnosis of diabetes were invited to monthly group education events, attended by

among others GPs, nurses, and dieticians. The medical secretary responsible for referrals and arrangement of treatment also attended, so that patients could meet a named point of contact within the system.

Bewick Crescent Surgery

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 Bewick Crescent Surgery

Bewick Crescent Surgery consists of six partner GPs, five male and one female, and four salaried GPs. The practice provides general medical services (GMS) to approximately 13,800 patients in the catchment area of Newton Aycliffe, which is the Durham Dales, Easington and Sedgefield Clinical Commissioning Group (CCG) area. There is also a part-time branch surgery for walk-in appointments at 30/31 West Green in Heighington, which was not inspected as part of this inspection.

There is a team of six practice nurses, a nurse practitioner, and four healthcare assistants. These are supported by a practice manager, assistant practice manager and a team of reception, administrative and dispensing staff. The practice is a training practice and was supporting two GP registrars and a student at the time of inspection.

The practice is open between 8am and 6pm Monday to Friday, and until 7:30pm on Wednesday. Appointments are from 8:15am every morning, with the last appointment at 7:15pm on Wednesday evenings. Patients can also access Saturday appointments from 8am until 12 noon through the 111 service or as emergency walk-ins.

The branch surgery is open from 8:30am until 10:00am Monday to Wednesday, and Friday, and 9:30am until 11 am on Thursday for nurse appointments. It is also open from 4pm until 5:30pm Monday and Thursday.

The practice has higher levels of deprivation compared to the England average. There are higher levels of people with caring responsibilities or claiming disability living allowance, and higher levels of certain chronic diseases such as heart disease and diabetes. The practice has opted out of providing Out of Hours services, which are provided through Urgent Care Centres at Bishop Auckland or Darlington hospitals. The practice is a member of the 'South Durham Health CIC' Federation, a collaborative of 24 GP practices in County Durham.

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:

Detailed findings

- 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 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 two members of the Patient Participation Group.

We carried out an announced inspection on 10 September 2015.

We reviewed all areas of the main surgery site, including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with management staff, GPs, nursing staff, and administrative, dispensing and reception staff.

We observed how staff handled patient information received from the out-of-hours' team and patients ringing the practice. We reviewed how GPs 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 and learning from incidents

Safety was monitored using information from a range of sources such as National patient safety alerts (NPSA), which were disseminated to staff. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally where appropriate. Staff said they felt encouraged to report incidents. There were management and clinical leads for significant events. Significant events were discussed quarterly and learning points and actions noted, although these were not always explicit in who should carry out the actions and by when.

We looked at recorded summaries and analysis of incidents from the previous 12 months. There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. The practice did not carry out a yearly trends and themes analysis of significant events, but planned to introduce this.

Safe systems and processes including safeguarding

There were arrangements in place to safeguard adults and children from abuse. Staff were able to demonstrate they understood their responsibilities in recognising and reporting abuse, and adhered to the practices safeguarding policies and procedures. Staff had easy access to policies and contact details for organisations such as social services, and had received safeguarding training. There were designated safeguarding leads for children and adults, who staff were able to name.

The practice participated in joint working arrangements and information sharing with other relevant organisations including health visitors and the local authority. This included the identification, review and follow up of children, young people and families living in disadvantaged circumstances, including children deemed to be at risk. The practice participated in meetings on a quarterly basis to review all children on the 'at risk' register or children who were of concern with the Health Visitor and School Nurse.

There was a chaperone policy in place, and GPs noted on patient records when a chaperone had been offered or refused. Staff who could be asked to chaperone had received appropriate training.

Infection Control

We observed the practice to be clean, tidy and well maintained, and staff followed appropriate infection control and cleaning procedures. Staff had received appropriate training. Cleaning standards carried out by an external contractor were audited regularly.

There had been a recent infection control audit carried out, which had some minor findings which were being addressed. While stock in consulting and treatment rooms was checked regularly and in date, we did find some sterile and clinical items which were stored out of date in the main store area. These included sterile forceps expired in April 2015 and a vapour cooling spray expired in February 2015. There was no clear responsibility for checking and stock rotation in this room. It was therefore no longer possible to know whether these instruments and equipment were sterile at the point of use, and could pose an infection risk.

Medicines Management

The branch service provided a dispensing service to a small number of patients. There was a patient medication delivery service for those patients who were unable to attend the surgery.

Medicines in the treatment rooms 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. Dedicated members of staff were responsible for ordering and stock checking of medicines, and for cold chain procedure. There was a process for checking regularly that refrigerated and emergency medicines were within their expiry dates, and medicines we checked were within date. Expired and unwanted medicines were disposed of in line with waste regulations. There were protocols in place for the ordering, receipt, storage and disposal of medicines, which staff adhered to. Dispensing staff had received appropriate training.

The practice had a repeat prescribing protocol, with processes to check the issue of repeat prescriptions,

Good

Are services safe?

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.

Equipment and Emergency Procedures

Medical equipment including emergency equipment, electrical equipment, and fire detection and alarm equipment were all serviced and maintained according to appropriate schedules overseen by the assistant practice manager. Staff knew how to report faults with equipment. The practice had a defibrillator available on the premises and oxygen, both of which were checked regularly and maintained.

The practice had procedures in place for medical and other emergencies, evacuation plans, and a business continuity plan for events such as power cuts or flood, although staff awareness of this plan was generally low. Staff had received fire safety training and regular drills were carried out.

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.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There were arrangements in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Rotas were planned and agreed in advance between staff and the practice manager. All staff agreed that their staffing levels were sufficient. Skill mix had been reviewed and staff development promoted, to allow flexibility in cover and planning. For instant all dispensing staff could also work in reception. The practice had no current vacancies, and had excellent staff retention, with seven out of the 10 GPs having previously been in training at the practice.

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. Staff identified and responded to changing risks to patients who used the practice by monitoring them for deteriorating health and wellbeing. Patients with a change in their condition were reviewed and referred appropriately.

There were procedures in place to assess, manage and monitor risks to patient and staff safety, including room checks and reporting procedures.

A health and safety policy and risk assessments were in place for the safe running of practice, which were kept under review and changes made as necessary. All new employees working in the building were given induction information for the building which covered health and safety and fire safety.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Assessing patient need and monitoring outcomes

The practice accessed current evidence-based guidance, standards, and best practice such as information from the National Institute for Health and Care Excellence (NICE) and other professional bodies. NICE guidelines were disseminated and discussed regularly at clinical meetings. The practice used this information to develop how care and treatment was delivered to meet needs, such as a review of aspirin use and antibiotic prescribing. 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 GPs and communicated regularly, for instance the diabetic clinic was GP led.

The practice collected information about people's care and outcomes. These included scores from national incentive schemes (the Quality and Outcome Framework, or QOF) and clinical audits. QOF results from 2013-14 showed the practice achieved 95.4% of the total points available, above the national average of 94.2%. Examples of QOF data from 2013-14 included the percentage of eligible women who had a cervical screening test performed in the last 5 years was 82.8%, slightly above the national average of 81.88%.

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a

comprehensive, agreed care plan documented in the record, in the preceding 12 months was above the national average of 86.04%, at 92.65%.

Nursing staff were able to discuss their involvement in audits such as cervical smears, contraception implant removal dates and contra-indications for use of the contraceptive pill. Examples of GP clinical audits included monitoring of patients with hypothyroidism and use of anticoagulant medicines. Audits contained recommendations, such as recalling patients for review appointments, and a date for re-audit to gauge success of changes made. However there was a lack of evidence around completed clinical audits where the practice could clearly demonstrate an improvement in patient outcomes, as many of the audits were relatively new therefore had not been re-audited.

The practice also met with the local CCG to discuss performance, and participated in benchmarking in areas such as A&E attendance rates and prescribing rates. The practice had identified their most vulnerable patients, who were at risk of an unplanned admission to hospital, and had produced 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 multi-disciplinary meetings were held to discuss the needs of patients, for instance on the unplanned admissions register, requiring palliative care, or with long-term conditions to ensure their needs assessment remained up to date. Regular ward rounds were carried out in local nursing homes by Advanced Nurse Practitioners employed by the Federation to ensure the needs assessment of vulnerable patients remained up to date.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register, learning disabilities and palliative care register. They also provided annual reviews to check the health of patients with learning disabilities and mental illness.

Effective staffing

The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality, in addition to further role specific training and shadowing of other members of staff. We spoke with staff who had received mentorship and supervision to allow them to learn and develop in their role.

Staff received mandatory training that included safeguarding, basic life support and information governance awareness. Staff had access to additional training related to their role. We saw evidence that GPs had undertaken annual external appraisals and participated in the revalidation process. Continuing Professional Development for nurses was monitored as part of their yearly appraisals process, and professional qualifications were checked yearly to ensure clinical staff remained fit to practice.

GP registrars, medical students and nurses were able to access GP led clinical supervision. GPs participated in peer review, such as an assessment of referral rates and

Good

Are services effective?

(for example, treatment is effective)

appropriateness. GP registrars were given a debrief at the end of each surgery for six months, and also access video consultations and peer support. Staff were able to access protected learning time (PLT) each month through the CCG where a variety of topics were discussed. In addition, nursing staff had a protected one hour per week for training and personal development. Healthcare assistants did not have this protected time, however were able to build in personal development time throughout the week.

Nursing staff said they were able to meet with the GPs regularly, for clinical supervision and best practice discussions, and that GPs were approachable. Staff said they felt confident in their roles and responsibilities, and were encouraged to ask for help and support. Staff said they found the appraisal process useful, as they were able to identify training needs which they then subsequently accessed. All staff we spoke with were extremely positive around the training they received at the practice. All staff had clear roles and responsibilities, and had been supported to develop clinical lead roles or additional responsibilities. Examples of further training staff had accessed to allow them to extend their role included a degree on day release to become a nurse practitioner, nurse prescriber training, and dispensing training. Seven out of the 10 GPs currently at the practice had previously been in training at the practice, and had either stayed on or returned.

Working with others and Information Sharing

Regular multi-disciplinary meetings were held with district nurses, health visitors, Macmillan nurses and clinical staff to identify and discuss the needs of those requiring palliative care, or safeguarding issues. GPs attended clinical meetings at local hospices. Attached advanced nurse practitioners carried out 'Ward rounds' on patients in nursing homes, and communicated with GPs as part of a CCG initiative.

Regular clinical and non-clinical staff meetings took place, and staff described communication throughout the practice as excellent. The practice provided GP services to a young person's secure unit in the area, and once a week both a male and female GP visited to provide medical care on a multidisciplinary basis.

Blood results, discharge letters and information from out of hours providers was received electronically and disseminated to the relevant member of clinical staff or the on call doctor. Where necessary a procedure for scanning documents was in place. A flagging system was used to identify urgent test results and these were prioritised for action. The GP recorded their actions around results or arranged to see the patient as clinically necessary. Patients were referred to hospital using an electronic referral system and used the two week rule for urgent referrals such as cancer.

The practice liaised with the out of hours provider regarding any special needs for a patient; for example regarding end of life care arrangements for patients who may require assistance over a weekend. 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. Patients ringing 111 could be booked straight into the surgery for emergency appointments.

The practice worked with external organisations such as the Citizens Advice Bureau (CAB). The CAB attended a weekly session in the surgery to give patients advice.

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.

An area for recording consent was included in treatment templates, and was documented on the computer as part of a consultation. Staff were able to explain how they would discuss a procedure, detailing risks and benefits. Written consent forms were used from minor operations, then scanned and stored on the system. There was a consent to video consultations taking place with a trainee GP, which the patient then signed before and after consultation to make sure they were happy with this.

GPs and some clinical staff had received training around the Mental Capacity Act 2005 and deprivation of liberty safeguards, and were able to demonstrate an awareness of the law and issues surrounding capacity. Clinical staff who had not received this specific training described consent issues as being covered in other training modules, such as

Good

Are services effective?

(for example, treatment is effective)

safeguarding. However staff were confident in discussing how they would deal with consent issues, including how they would involve parents and carers, and escalate to a senior member of staff for advice where necessary.

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. Nursing staff told us how they had wished to reintroduce physical new patient checks, rather than just assessment via questionnaire. The practice was supportive in this and the checks commenced. Nursing staff used these checks to identify and register carers, and identify long-term conditions, where the patient could be diverted into a specialist clinic with minimal delay.

Nurses used chronic disease management clinics where patients were seen for multiple conditions to promote healthy living and ill-health prevention. People with a new diagnosis of diabetes were invited to monthly group education events, attended by among others GPs, nurses, and dieticians. The medical secretary responsible for referrals and arrangement of treatment also attended, so that patients could meet a named point of contact within the system. Nurses were able to develop in their specialist interest areas, such as women's health and mental health, and had undertaken further training and qualifications.

Patients over the age of 75 had been allocated a named GP and were encouraged to attend for yearly health checks. QOF data from 2013-14 showed percentages of patients aged 65 or over, or in a risk group receiving a flu vaccination were around the national average. During flu immunisation season the practice held a weekend walk-in clinic and nurses undertook home visits to immunise housebound patients.

Patients could access a walk in 'well person' clinic on Wednesday evenings for healthy lifestyle advice, new patient checks, cervical smears and early detection of illness. The family planning clinic could also be accessed by patients not registered with the surgery. Learning disability patients were given a 'health action plan', which was an easy read summary of their health checks, which they could then take away with them and bring to the next appointment. The practice Healthcare Assistants (HCA) had received an award from the County Durham NHS stop smoking service for high quit rates achieved.

Immunisation rates were around the average for all standard childhood immunisations. Midwives ran antenatal clinics jointly with the GPs on a weekly basis. After birth, both mothers and babies were seen by GPs at eight weeks for checks with nurse-led immunisation clinics held at the practice. These clinics were held at convenient times before school ended.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

In the latest NHS England GP Patient Survey of 112 responses, patient satisfaction was generally similar to local and national averages for instance:

- 89% say the last GP they saw or spoke to was good at giving them enough time

Local (CCG) average: 90% National average: 87%

- 85% say the last GP they saw or spoke to was good at treating them with care and concern

Local (CCG) average: 88% National average: 85%

- 93% say the last nurse they saw or spoke to was good at treating them with care and concern

Local (CCG) average: 94% National average: 90%

We spoke to two members of the Patient Participation Group (PPG) and six patients as part of the inspection. We also collected 66 CQC comment cards which were sent to the practice before the inspection, for patients to complete.

The vast majority of feedback we collected indicated patients were satisfied with the service provided. Patients said they were treated with dignity and respect, and that staff were pleasant and friendly.

Patients said they were confident with the care provided, and that staff took the time to listen to them. Some patients gave specific examples of where they had been satisfied with the level of care and kindness demonstrated by the doctor and all staff. There was some information on bereavement services in reception, and doctors could refer patients to local counselling, mental health services or specialist attached community psychiatric nurses. The practice worked with Macmillan nurses and the local hospice in following end of life care pathways. 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 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.

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

The latest NHS England GP Patient Survey of 112 responses showed:

- 85% say the last GP they saw or spoke to was good at involving them in decisions about their care

Local (CCG) average: 86% National average: 81%

- 88% say the last GP they saw or spoke to was good at explaining tests and treatments

Local (CCG) average: 89% National average: 86%

The templates used on the computer system for people with long term conditions supported staff in helping to involve people in their care, and staff updated these to reflect latest guidance. Nursing staff provided examples of where they had discussed care planning and supported patients to make choices about their treatment, including referral to specialist or community nursing staff. 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, and comment cards received, 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.

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

Good

Are services caring?

practice could access information leaflets in other languages. There was a hearing loop at reception. There was an alert on the patient system so staff were aware of patient specific needs when the appointment was made and when they attended the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting different people's needs

The practice worked with the local CCG to improve outcomes for patients in the area, and had recognised the needs of different groups in planning its services. For example, those patients assessed as vulnerable under the unplanned admissions schemes had same day access to a GP. Their records were coded to enable surgery staff to identify these patients when they contacted the practice and respond accordingly.

The practice had initiated and led a suicide prevention project which subsequently extended to cover three practices within Newton Aycliffe. The practice proposed the project due to concerns over increasing suicide rates in County Durham. Supported by the Federation and the CCG, the practice employed and managed on behalf of the Federation community psychiatric nurses as an additional service between mental health crisis teams and routine care. Patients referred to the service would be given an hour-long appointment within two days at any one of three practices within the area. There had been no adult suicides in the area since the inception of this scheme.

Telephone consultations and a home delivery service for medication were available, to help patients who were housebound or may otherwise struggle to access the surgery. Children under the age of five had same day access to a GP, and there was a practice policy to slot in urgent problems even when they were no appointments left, to save the patient having to attend at an urgent care centre. Practice GPs carried out early morning home visits before 10am, so that someone who had been ill from the night before did not have to wait till the afternoon for a visit. Longer appointments could be made available for those with complex 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. The practice worked closely with the CCG to discuss local needs and priorities. The practice had a forward plan which looked at staff rotas and skill mix, and QOF projections, such as the number of dementia or diabetic reviews which needed to be held, and therefore which staff were needed to cover these.

Home visits and telephone appointments were available where necessary. The building accommodated the needs of people with disabilities, incorporating features such as level access, accessible toilet facilities and automatic doors. Treatment and consulting rooms were on the ground floors. Disabled parking spaces were available in the car park outside. Reception staff had recently been trained to be 'dementia friends' to help people access services in reception.

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. 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 also be ordered online. A mix of pre-bookable up to two weeks in advance, and 'on the day' appointments were available.

The practice was open from 8:30am until 6.00pm four days a week, and until 7:30pm on Wednesday evenings. This benefited people of working age, who could access GPs, health checks, smear tests and a family planning clinic from 5:30pm. The branch surgery had only walk-in clinics including one nurse clinic, in response to patient surveys. There were plans to introduce a second nurse clinic in response to the loss of a local bus service, meaning patients found it harder to access the main surgery. Patients could also access Saturday appointments from 8am until 12 noon through the 111 service, or for patients who could access service at no other time.

The latest NHS England GP Patient Survey of 112 responses showed patients were generally satisfied with their to the service, for instance:

- 76% of respondents usually wait 15 minutes or less after their appointment time to be seen

Local (CCG) average: 70% National average: 65%

- 84% of respondents are satisfied with the surgery's opening hours

Local (CCG) average: 81% National average: 75%

- 75% of respondents find it easy to get through to this surgery by phone

Good

Are services responsive to people's needs?

(for example, to feedback?)

Local (CCG) average: 80% National average: 73%

The numbers of book on the day or pre-bookable appointments were adjusted according to predicted need. Staff numbers and required skill mix were planned three weeks in advance, and these were discussed and agreed between clinical and management staff in advance. On the day of inspection, we saw that patients were called at or near to their appointment time.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Information on how to complain was displayed in reception.

We looked at a summary of complaints made in the last 12 months, and could see that these had been responded to with an explanation and apology where necessary. The practice had carried out a patient survey in 2013-14, which had 607 responses. An action plan was then drawn up and agreed with the PPG, such as improving provision of care for dementia patients. There was an electronic terminal in reception where patients could leave feedback through the 'Friends and Family' test, although this was not particularly obvious, and many patients we spoke with were unaware of how to leave feedback. Practice action plans were available on the practice website, although these were not displayed in reception. Patients we spoke with said they would feel comfortable raising a complaint if the need arose.

Are services well-led?

Good

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

Our findings

Vision, Strategy and Culture

The practice had a clear forward plan, with an awareness of issues within the local area which would impact on future care provision, such as an ageing population. The practice engaged in future planning schemes with the CCG, patient groups and other practices within the area to improve patient outcomes and enhanced integrated care across the local area. The practice had aims and objectives contained in their statement of purpose, which included to promote patient choice and confidentiality.

Staff were familiar with and engaged with the values and ethos of the practice. Staff we spoke with agreed that communication within their own teams and as a practice was good, and they formed a strong supportive environment, where people worked flexibly and supported one another.

Staff had individual objectives via their appraisal, such as clinical staff looking to develop their knowledge in a certain area to be able to offer additional service. Staff described the appraisal process as useful and stated they were able to identify and follow up on learning objectives through these. Staff told us that regular team meetings were held. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did.

Governance Arrangements and Improvement

Staff were clear on their roles and responsibilities, and felt competent and trained in their roles. 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, infection control procedures and human resources policies had been reviewed and were up to date, or were being reviewed. 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 practice regularly reviewed its results and how to improve, and was proactive in using patient contact to promote additional screening or review services. The practice had developed a QOF projection plan with areas where they needed to target resource, and to map required skill mix amongst staff. We saw from meeting minutes that the practice looked to continuously improve the service being offered, and wished to encourage and foster a learning culture. We saw evidence that they used data from various sources including patient surveys, incidents, complaints and audits to identify areas where improvements could be made.

The practice had identified lead roles and deputies for areas such as, safeguarding, palliative care, chronic disease management and infection control. Some clinical audits were 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 arrangements for identifying, recording and managing risks. Management staff demonstrated awareness of potential risks and health and safety assessments which addressed a range of health, safety and welfare issues, such as legionnaires risk assessment or recruitment checks for staff.

The practice carried out a quarterly review of complaints, and compared these against the same period in the previous year so that they were able to analyse trends and themes. We could see were learning and action points had been documented, for example provision of extra training for staff.

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

Staff including salaried GPs felt confident in raising concerns or feedback, and were able to give examples of where they had effected change, for instance the re-introduction of physical new patient health checks.

There was an active Patient Participation Group (PPG), which met every two months. This group was currently fully subscribed and had a waiting list. A PPG representative told us and we saw from minutes, that the practice asked them for feedback. The practice PPG had formed a strategic group with another practice PPG in the area which aimed to work working together to develop and identify how to enhance and protect the services currently available to the patients in the geographic area, working in conjunction with GPs and practice managers.

Are services well-led?

Good

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

The practice offered a work experience scheme for sixth form students with an interest in studying Medicine at university, to spend 2-3 days in the practice, (without direct patient contact) and encouraged feedback about the practice from this age group.

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.