The Village Green Surgery

Quality Report

The Village Green Surgery, The Green,
Wallsend, Tyne and Wear, NE28 6BB
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Date of inspection visit: 24 March 2015
Date of publication: 13/08/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Village Green Surgery on 24 March 2015. Overall, the practice is rated as outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Information about safety was appropriately recorded and reviewed;
- Risks to patients were assessed and well managed;
- The practice was clean, hygienic and good infection control arrangements were in place;
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- The practice had scored very well on clinical indicators within the quality outcomes framework (QOF). They achieved 99.3% for the year 2013/14, which was above the average in England of 96.47%;
- Patients said they were treated with compassion, dignity and respect and that they were involved in decisions about their care and treatment;
- Information about the services provided and how to raise any concerns or complaints, was accessible and easy to understand;
- Most patients said they found it easy to make an appointment and urgent same-day access was available;
- The practice had good facilities and was well equipped to treat patients and meet their needs;
- The practice was clean and effective arrangements were in place to reduce the risk of infections;
- There was a clear leadership structure and staff felt supported by management. The practice actively sought feedback from patients;
- We found there was good staff morale in the practice, with high levels of team spirit and motivation. There was a strong learning culture evident in the practice. This came across clearly through staff interviews, but was also evident in the approach to adopting and championing new initiatives and technology. The practice took a leading role in identifying new resources and sharing these with other practices across the locality.

We saw several areas of outstanding practice including:

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- The Medicines Optimisation for patients in the local care home resulted in significant reduction in medicines prescribed. (Medicines optimisation is an approach which seeks to maximise the beneficial clinical outcomes for patients from medicines with an emphasis on safety, governance, professional collaboration and patient engagement). The practice calculated the approach had resulted in a 17%decrease in medicines prescribed, with no untoward effects reported. The results of this project were reported on at the National Pharmacy Congress conference in April 2015 as an area of good practice.
- The practice directly employed a pharmacist and we found their support had led to improvement in outcomes for patients.
- The multi-disciplinary diabetic clinic, which supported good outcomes for patients with diabetes. Patients had access to advice from the dietician and retinal screening during the clinic and following the clinic the diabetic team met to discuss any concerns or queries. This service was well regarded by patients. Performance against the Quality Outcomes Framework (QOF) for diabetes mellitus was at 99.8%, which was 5.8 percentage points above CCG Average and 9.7 above England Average.
- There was strong evidence throughout the practice that team spirit and motivation was high. Of particular note was the general feeling of 'all of us feel valued and of equal importance'.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Evidence showed the practice had managed safety incidents and information consistently over time and could show evidence of a safe track record over the long-term. The practice was open and transparent when there were near misses or when things went wrong. Lessons were learned and communicated widely to support improvement.

The practice had regular monthly multidisciplinary meetings to discuss the safeguarding of vulnerable patients. Medicines were managed safely within the practice. Information about safety was recorded, monitored, appropriately reviewed and addressed. The practice was clean and effective arrangements were in place to reduce the risk of infections. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up-to-date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients.

Data showed that the practice performed highly when compared to neighbouring practices in the CCG. The practice was using innovative and proactive methods to improve patient outcomes, for example, clinical staff were optimising the use of medicines for older people in care homes and for older people on the practice's chronic disease registers.

The practice had well established procedures for reviewing the needs of patients with diabetes, in conjunction with other health professionals. We found the practice was supporting people to live healthier lives through health promotion and prevention of ill health. There was good evidence of how the practice worked with other healthcare professionals, and involved patients in decisions about their care, to improve health outcomes.

Are services caring?

Good

The practice is rated as good for providing caring services. GP Patient survey Data showed that patients rated the practice in line

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with or higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Staff reviewed the needs of their local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The majority of patients said they found it easy to make an appointment with a named GP. There was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet most of their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding

The practice is rated as outstanding for providing well-led services. They had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. There was strong evidence throughout the practice that team spirit and motivation was high.

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. There was a strong learning culture evident in the practice. This came across clearly through staff interviews, and was also evident in the approach to adopting and championing new initiatives and technology. The practice took a leading role in identifying new resources and sharing these with other practices across the locality. The practice actively shared those areas of innovation and good practice they identified with other local practices to help improve health services locally.

The practice proactively sought feedback from staff and patients, which they acted on. Staff had received an induction, and underwent regular performance reviews and attended staff meetings and events.

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The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in their population. The practice was using innovative and proactive methods to improve patient outcomes, for example, optimising the use of medicines for older people in care homes and for older people on the practice's chronic disease registers. Staff were responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. These patients had a named GP and a structured annual review to check that their health and medication needs were being met. The practice had well established procedures for reviewing the needs of patients with diabetes, in conjunction with other health professionals. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good ●

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were in line with local averages for all standard childhood immunisations. For example, MMR vaccination rates for five year old children were 96.6% compared to an average of 98.3% in the local CCG area. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Cervical screening rates for women aged 25-64 were above the national average at 91.8%, compared to 81.9%.

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Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services they offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances including those who misuse substances and those with a learning disability. They carried out annual health checks for people with a learning disability. They offered longer appointments for those who required them.

Staff had told vulnerable patients about how to access various support groups and voluntary organisations. They knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people with poor mental health (including patients with dementia).

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

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

Summary of findings

What people who use the service say

We spoke with 10 patients during the inspection. This included three patients from the practice Patient Participation Group (PPG).

Patients told us staff were generally friendly, and treated them with dignity and respect. Although some of the patients we spoke with told us that one or two staff were abrupt or rude to them at times. They told us the majority of time when they saw clinical staff, they felt they had enough time to discuss the reason for their visit and staff explained things to them clearly in a way they could understand. Patients told us they could normally get an appointment easily, although at times it was difficult to get through on the phone lines. They told us they could always get an appointment quickly if there was an urgent need. Patients were generally happy with the appointments system.

We reviewed 59 CQC comment cards completed by patients prior to the inspection. The majority of patients who completed these cards commented positively on the practice, staff and the care and treatment offered. In particular, patients commented on the good service received in the diabetic clinic and the good listening skills and empathy demonstrated by GPs. A number of cards identified GPs, practice nurses and other staff who respondents felt deserved particular praise. Words used to describe the practice included 'excellent', 'friendly', '10 out of 10', and 'superb'. One carer commented on the excellent coordination the practice had offered during end of life care, enabling a relative to die at home with dignity. Another commended the practice on the support they had received following the death of their spouse.

Whilst three comment cards included negative comments about specific issues within the practice, all three also stated how satisfied they were generally. Three commented on the difficulty of making appointments, and one commented on what they perceived as a delay in diagnosis.

The latest National GP Patient Survey published in 2015 showed the majority of patients were satisfied with the services the practice offered. The majority of patients who responded described their overall experience as good. (87.7% compared to a national average of 85.2%).

The three responses to questions where the practice performed the best when compared to other local practices in the Clinical Commissioning Group (CCG) were:

- 99% of respondents say the last appointment they got was convenient. (The local CCG average was 93%);
- 94% of respondents find the receptionists at this surgery helpful. (The local CCG average was 90%);
- 81% of respondents describe their experience of making an appointment as good. (The local CCG average was 78%).

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

- 60% of respondents usually wait 15 minutes or less after their appointment time to be seen. (The local CCG average was 72%);
- 80% of respondents say the last nurse they saw or spoke to was good at involving them in decisions about their care. (The local CCG average was 86%);
- 86% of respondents say the last nurse they saw or spoke to was good at treating them with care and concern. (The local CCG average was 92%).

These results were based on 129 surveys that were returned from a total of 338 sent out; a response rate of 38.2%.

Outstanding practice

- The Medicines Optimisation for patients in the local care home resulted in significant reduction in medicines prescribed. (Medicines optimisation is an approach which seeks to maximise the beneficial

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clinical outcomes for patients from medicines with an emphasis on safety, governance, professional collaboration and patient engagement). The practice calculated the approach had resulted in a 17% decrease in medicines prescribed, with no untoward effects reported. The results of this project were reported on at the National Pharmacy Congress conference in April 2015 as an area of good practice.

- The practice directly employed a pharmacist and we found their support had led to improvement in outcomes for patients.
- The multi-disciplinary diabetic clinic, which supported good outcomes for patients with diabetes. Patients had access to advice from the dietician and retinal screening during the clinic and following the clinic the diabetic team met to discuss any concerns or queries. This service was well regarded by patients. Performance against the Quality Outcomes Framework (QOF) for diabetes mellitus was at 99.8%, which was 5.8 percentage points above CCG Average and 9.7 above England Average.
- There was strong evidence throughout the practice that team spirit and motivation was high. Of particular note was the general feeling of 'all of us feel valued and of equal importance'.

The Village Green Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A **CQC Lead Inspector.** The team included a GP and a specialist advisor with experience of GP practice management.

Background to The Village Green Surgery

The Village Green Surgery is located near the centre of Wallsend, on the same site as the Sir GB Hunter Memorial Hospital and Wallsend Hall. The practice provides services to just over 9700 patients. The practice provides services from the following address, which we visited during this inspection:

The Village Green Surgery, The Green, Wallsend, Tyne and Wear, NE28 6BB.

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

The practice has seven GP partners and the practice manager is also a partner. There are also two salaried GPs, three GP registrars (fully-qualified doctors who spend time working in a practice to develop their skills in general practice), four practice nurses, three practice nursing assistants and a team of administrative support staff.

The premises are purpose built and provide fully accessible treatment and consultation rooms for patients with mobility needs. Patient facilities are on the ground floor. There is a disabled WC. There is a car park in the grounds of the practice and nearby parking on the street.

The practice provides a range of services and clinics, including for example, for patients with asthma, diabetes and heart failure.

Surgery opening times are Monday to Friday 8.30am to 6.30pm, with late surgeries Tuesday and Thursday until 8.00pm for pre-booked appointments only. The service for patients requiring urgent medical attention out-of-hours is provided by the 111 service and Northern Doctors Medical Services Limited.

The practice serves an area with higher levels of deprivation affecting children and people aged 65 and over, when compared to other practices in the local CCG, and the England average. It is estimated that 0.9% of the population are from non-white ethnic groups. The practice's population includes more patients within working age, (between 18 and 65) than other practices in the local CCG area and the England average.

The average male life expectancy is 78 years and the average female life expectancy is 82. These are both one year less than the England average. The number of patients reporting with a long-standing health condition is slightly higher than the national average (practice population 55.9% compared to a national average of 54.0%). The number of patients with health-related problems in daily life is higher than the national average (54.5% compared to 48.8% nationally). There are a higher number of patients with caring responsibilities at 22.8% compared to 18.2% nationally.

Why we carried out this inspection

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

Detailed findings

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

How we carried out this inspection

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

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

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

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. This highlighted one indicator for us to follow up during the inspection. This related to patients diagnosed with certain mental health conditions who had a record of their alcohol consumption within the preceding 12 months. As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local Clinical Commissioning Group (CCG).

We carried out an announced visit on 23 March 2015. We spoke with 10 patients, including three members of the Patient Participation Group (PPG) and 14 members of staff. We spoke with and interviewed three GPs, the GP registrar, the practice manager, three practice nurses, a healthcare assistant, the practice pharmacist and four staff carrying out reception and administrative duties. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 59 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe track record

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

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

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

Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety. For example, the practice had identified improvements to the process for allocating home visits as a result of a significant event. Although in the initial incident the home visit was still conducted on the same day, the practice recognised improvement could be made to the process to build in further safeguards. They took a whole practice approach to improvement and identified actions each member of staff needed to take. There was good management oversight to ensure identified improvements were implemented and well embedded. However, the practice were looking to improve the way they recorded the outcomes from significant events to document more detail as to how they had followed up and reviewed the success of identified learning.

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

Learning and improvement from safety incidents

The practice was open and transparent when there were near misses or when things went wrong. The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to view these.

Significant events were a standing item practice meetings. We saw evidence that significant events were also discussed at dedicated 'time in' meetings and sessions to review actions from past significant events and complaints. We saw notes of these meetings over the last year which confirmed this. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration as a significant event or incident and they felt encouraged to do so. Staff told us they felt confident in raising issues to be considered at the meetings and felt action would be taken. A culture of openness operated throughout the practice, which encouraged errors and 'near misses' to be reported. Staff had access to the full history of incidents reported via the practice intranet.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We tracked 14 incidents and saw records were completed in a comprehensive and timely manner. Where follow up action was identified, we saw there were clear accountabilities and a priority and timescale given. We saw that the process in place helped the practice to identify where processes or systems needed to change, but also where things had gone well or worked successfully.

The practice also identified positive significant events, where they recognised events that demonstrated processes in place successfully reduced risks to patients. This helped them confirm what had gone well so they could ensure this continued.

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

We saw evidence of action taken as a result of significant events. For example, following a significant event the

practice had identified learning to improve the way they communicated with patients when there was a suspected diagnosis of cancer and to ensure patients understood test results when the GPs discussed this with them.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were added to the practice meeting agenda, where appropriate, to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received role specific training on safeguarding. We saw evidence that GPs had received level three training for safeguarding children. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, record safeguarding concerns and contact the relevant agencies in working hours and out-of-normal hours. Contact details were easily accessible on the practice intranet. Staff confirmed they regularly used the practice intranet to access information about policies and procedures.

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

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example, children subject to child protection plans or looked after children. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed.

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

There was a chaperone policy, which was available on the staff intranet page. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Reception staff acted as a chaperone. Receptionists had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. They had undergone appropriate police checks to ensure they were suitable to carry out this role.

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

Medicines management

Arrangements were in place to regularly monitor the GPs' prescribing practice. The practice employed a pharmacist for one day a week. They told us they supported the practice with medicines optimisation. (An approach which seeks to maximise the beneficial clinical outcomes for patients from medicines with an emphasis on safety, governance, professional collaboration and patient engagement). They carried out various audits, which we saw evidence of, to make sure medicines were being used effectively. They also provided the practice with advice and support.

We checked vaccines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a process for checking medicines were kept at the required temperatures and this was being followed by the practice staff. This ensured the medicines in the fridges were safe to use. Staff told us the action they had taken to safeguard

stored medicines during an incident when a fridge was found to be outside the normal range. All medicines were moved to another fridge to ensure they remained safe for administration.

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

Vaccines were administered by practice nurses using directions that had been produced in line with legal requirements and national guidance. We saw copies of directions that were signed by the nurse who used them.

A process was in place to handle medicines safety alerts. These were emailed to relevant staff, and that any decisions about whether action needed to be taken would be reviewed during the regular weekly clinical meetings.

Patients were able to order repeat prescriptions using a variety of ways such as by telephone, online and by post. The practice website provided patients with helpful advice about ordering repeat prescriptions. Staff knew the processes they needed to follow in relation to the authorisation and review of repeat prescriptions. We observed reception staff dealing effectively with requests for repeat prescriptions. There were safe processes in place to manage prescriptions issued under shared-care arrangements. (Shared-care is where a GP supports and prescribes treatment for a patient which was initiated by a specialist.)

A system was in place which helped to ensure patients who were receiving prescribed medicines were regularly reviewed. The GP we spoke with told us these reviews were carried out at least annually. The pharmacist had qualifications that allowed them to prescribe medicines. They had taken over some of the responsibility for reviewing medicines, for example for those patients on blood thinning medicines that need more regular monitoring.

Blank prescription forms were handled in accordance with national guidance and were kept securely, as were those awaiting issue. All prescriptions were reviewed and signed by a GP before they were given to the patient.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and procedures were in place and they covered a range of key areas such as, for example, obtaining specimens. These provided staff with guidance about the standards of hygiene they were expected to follow and enabled them to plan and implement measures to control infection. The policy had recently been reviewed. A comprehensive infection control risk assessment and audit had been completed in December 2014 in order to identify any shortfalls or areas of poor practice. A detailed action plan, with timescales for completion, had been prepared to address the shortfalls identified. As a part of this several areas of the practice had been identified for refurbishment and redecoration.

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

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

We saw a number of patients hand in specimens to reception staff to send away for testing. Gloves were available to staff to use in handling specimens. However, we noted a number of samples were handed in to the nurse receptionist who did not wear gloves or take other precautions to protect themselves and others from the risk of infection whilst handling specimens.

The clinical rooms we visited contained personal protective equipment such as latex gloves, and there were paper covers and privacy screens for the consultation couches. Arrangements had been made for the privacy screens to be regularly changed. Spillage kits were available to enable staff to deal safely with any spills of bodily fluids. Written instructions were in place informing staff how to do this. Sharps bins were available in each treatment room to enable clinicians to safely dispose of needles. The bins had

been appropriately labelled, dated and initialled. The treatment rooms also contained hand washing sinks, antiseptic gel and hand towel dispensers to enable clinicians to follow good hand hygiene practice.

Arrangements had been made to ensure the safe handling of specimens and clinical waste. For example, the practice had a protocol for the management of clinical waste and a contract was in place for its safe disposal. All waste bins were visibly clean and in good working order.

The practice had a legionella risk assessment carried out in June 2012. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal). This identified there was a low risk of legionella within the practice, and recommended the checking of the water temperature of the cleaners sink. The risk assessment stated that a further risk assessment be conducted after two years. The practice had not been carrying out the regular checks on the cleaners sink. Following the inspection the practice manager provided evidence that they had arranged for an updated new risk assessment to be carried out, had purchased a legionella testing kit and had implemented regular checks.

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. The equipment was regularly inspected and serviced. We saw records confirming, where appropriate, the calibration of equipment had been regularly carried out.

Practice staff monitored the safety of the building to ensure patients were not put at risk. Regular checks of fire equipment had taken place. For example, an up-to-date fire risk assessment was in place. Weekly fire alarm tests were carried out by staff. The practice had an evacuation plan which informed staff how the building should be evacuated in the event of an emergency. The practice manager told us that they had not had a fire drill in some time. They had recognised this as an area for improvement and had one planned for June 2015. We checked the building and found no evidence of particular risks or hazards. None of the patients we spoke to had any concerns about their safety when visiting the practice.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks where appropriate through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards they followed when recruiting clinical and non-clinical staff. Where non-clinical staff undertook tasks that put them in contact with vulnerable people, such as when they acted as a chaperone, they had a DBS check in place to demonstrate they were suitable to undertake this role.

The practice manager routinely checked the professional registration status of GPs and nurses (for GPs this is the General Medical Council (GMC) and for nurses this is the Nursing and Midwifery Council) each year to make sure they were still deemed fit to practice. We saw records which confirmed these checks had been carried out.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying on the regulated activities. The practice manager showed us the comprehensive system the practice had in place to determine the right skills mix. Staff told us there were effective arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff we spoke with were flexible in the tasks they carried out. This demonstrated they were able to respond to areas in the practice that were particularly busy. For example, within the reception on the front desk receiving patients or on the telephones.

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

Monitoring safety and responding to risk

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

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

care needs had been entered onto an electronic system which provided emergency professionals and out-of-hours clinical staff with access to information about how best to meet their needs. Data we looked at showed emergency cancer admissions per 100 patients on the disease register were similar to average. As were the number of emergency admissions for a number of ambulatory care conditions per 1,000 population. These are chronic conditions for which it is possible to prevent deterioration and the need for hospital admission through active management of the condition and lifestyle interventions.

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

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

Arrangements to deal with emergencies and major incidents

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

The practice had an up-to-date business continuity plan for dealing with a range of potential emergencies that could impact on the day-to-day operation of the practice. Staff were able to easily access it if needed. Risks were identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather and access to the building. The document also included relevant contact details for staff to refer to. For example, the numbers for utility suppliers to contact in the case of failure, such as during a flood or power cut.

Staff had received training in cardio-pulmonary resuscitation (CPR). Emergency equipment was available, including an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The staff we spoke with knew the location of this equipment and we were able to confirm that it was regularly serviced. However, there was no evidence to confirm that regular checks took place to ensure the defibrillator was operational (battery charged) and that pads were in date. The practice manager confirmed the practice had put in place checks following the inspection.

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

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

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

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

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

Nationally reported data taken from the Quality Outcomes Framework (QOF) for 2013/14 showed the practice had achieved 99.3% of the points available to them for providing recommended treatments for the most commonly found clinical conditions. This was 2.5 percentage points above the local Clinical Commissioning Group (CCG) and 5.8 above the England average. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.)

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

Management, monitoring and improving outcomes for people

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

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

The practice had a system in place for completing clinical audit cycles. The practice showed us a sample of two of the eight clinical audits undertaken within the last year. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, the practice had audited treatment for atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate) to check it complied with clinical guidance from the National Institute for Health and Care Excellence (NICE). The follow up audit found improvements had been made to patient care as a result. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the QOF. The practice provided us with a list of other audits and data collections they had undertaken to give reassurance in relation to the prescribing of medicines. For example, the practice looked at the prescribing of topical medications for a common ear condition in line with NICE guidance.

Other clinical audits completed included minor surgeries; cervical smear results; and, identification of breast cancer patients on aromatase inhibitors (which stop the production of oestrogen in postmenopausal women) to ensure NICE guidance was followed in relation to further tests and treatment.

The practice directly employed a pharmacist and we found their support had led to improvement in outcomes for patients.

The practice was participating in the Health Foundation's Shine 2012 programme. This project was developed by Northumbria Healthcare NHS Foundation Trust to optimise the use of medicines with care home residents, ensuring that they or their families were fully involved in any decisions around prescribing and de-prescribing. For each patient in the local care home, the pharmacist undertook a detailed medication review using primary care records. The results were discussed at a multidisciplinary team (MDT) meeting involving the care home nurse and the resident's GP, with input from the local psychiatry of old age service (POAS) where appropriate. Suggestions for medicines which should be stopped, changed or started, and other interventions (for example monitoring) were discussed with the resident and/or their family. The practice calculated this resulted in a 17% decrease in medicines prescribed, with no untoward effects reported. The care home calculated this equated to one hour of care time released each week due to less administration of medicines. The practice also found evidence that 60 admissions to hospital were prevented as a result of this approach. The practice also identified significant cost savings associated with this, with an estimated net annualised saving of £184 per person and for every £1 invested, they calculated £2.38 could be released from the medicines budget. The results of this project were reported on at the National Pharmacy Congress conference in April 2015 as an area of good practice.

The practice pharmacist also ran a clinic for older people on the practice's chronic disease registers to review and optimise the medicines prescribed.

The practice had arrangements in place to identify and review patients with diabetes. The practice ran weekly clinics for patients with diabetes. There was also a dietician and retinal screening available during these clinics. Four to six weeks prior to an annual review meeting, patients had a number of relevant tests conducted and foot checks completed. Patients were sent a copy of the results prior to their review. This allows patients to prepare questions and write down concerns prior to their review. At the annual review, all results were available for the clinician enabling them to develop a shared management plan with the patient. The diabetic team met post clinic to discuss any concerns or queries with regards to the morning clinic. Patients commented on the good service received in the diabetic clinic in the CQC comment cards. For example, one patient commented, "I have been here for years and the diabetic clinic is excellent". Another said, "The diabetic nurse has been very kind and helpful".

Overall, performance against the QOF for diabetes mellitus was at 99.8%, which was 5.8 percentage points above CCG Average and 9.7 above England Average. The percentage of patients with diabetes, on the register, who had a record of retinal screening in the preceding 12 months, was 94.2%, which was 5.4 percentage points above the CCG Average and 4.2 above England Average. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification within the preceding 12 months was 95.7%, which was higher than 5.5 percentage points above CCG Average and 7.4 above England Average.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice had achieved 100% of the total QOF points available to them for providing recommended treatments to patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (lung disease) and epilepsy.

The practice had a robust recall system in place to ensure patients were offered appointments to review their long-term conditions. Where patients did not attend review appointments, they were invited to attend three times. Where patients still did not attend, their medical records were reviewed to identify potential reasons for non-attendance. Where a patient was identified as being in

circumstances which might make them vulnerable which contributes to their non-attendance, the practice shared this information with community health professionals, such as the community matron and asked them to arrange a visit. GPs were also alerted to ensure that prescriptions were not issued for patients who had failed to attend their medicine review.

The practice was good at identifying patients who needed additional support and was proactive in offering this. For example, there was a register of all patients with dementia. Nationally reported QOF data for 2013/14 showed that: 90.9% of eligible patients with dementia had received a range of specified tests six months before, or after, being placed on the practice's register. (This was 8.6 percentage points above the local CCG average and 10.7 points above the England average.) 87.3% of patients on the dementia register had had their care reviewed in a face-to-face interview in the preceding 12 months. (This was 5 percentage points above the local CCG average and 3.5 points above the England average.) The practice had a system in place to identify patients who might be at risk of developing dementia. Staff told us this helped to ensure this group of patients received appropriate care and support, and clinicians were aware of their needs.

We saw evidence to confirm staff followed up abnormal blood test results, for example, for those patients on blood thinning medicines, with a telephone call to check the patient was aware of the results and were taking all medicines as prescribed and that they were generally well.

The practice had systems in place to identify patients, families and children who were most at risk or vulnerable. For example, practice staff told us that they had a register of patients who had a learning disability and also for those with poor mental health. They also told us that annual health checks were carried out for patients on these registers. QOF data demonstrated that registers were in place and that patients were having their health needs assessed on a regular basis. The practice was an outlier on one clinical indicator related to patients diagnosed with certain mental health conditions who had a record of their alcohol consumption within the preceding 12 months. Staff told us they were using information from the QOF to help them improve performance in this area.

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

Nationally reported QOF data for 2013/14 showed the practice had recorded the smoking status of 87.3% of eligible patients aged over 15. The data also showed the practice supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy, and this was in line with local and national averages.

Nationally reported QOF data for 2013/14 showed the practice had protocols that were in line with national guidance. This included protocols for the management of cervical screening, and for informing women of the results of these tests. The data showed that the records of 91.8% of eligible women, aged between 25 and 65 years of age, contained evidence they had had a cervical screening test in the preceding five years. (Compared to an England average of 81.9%).

The QOF data also showed 93.0% of eligible women, aged 54 or under, who were prescribed an oral or patch contraceptive method had received appropriate contraceptive advice during the previous 12 months. (This was 0.4 percentage points below the local CCG average and 3.6 points above the England average.) Overall, the data showed that the practice's performance in providing contraceptive services was 1.2 percentage points above the CCG Average and 5.6 above England Average at 100%. The practice also performed well in relation to the provision of maternity services. Their performance was in line with the local CCG and 0.9 above the England average at 100%.

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a

group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

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

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

Effective staffing

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

We reviewed staff training records and saw that all staff were up-to-date with attending mandatory courses such as basic life support. We saw there was a documented induction process for new employees.

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

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

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

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

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

Working with colleagues and other services

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

We saw various multi-disciplinary meetings were held. For example, the practice met weekly to discuss the needs of patients on the palliative care register. This meeting was attended by the GPs, practice nurses, practice administrative leads and the district nurses. Child protection meetings were held monthly with health visitors.

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service, were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff to pass on, read and action any issues arising from communications with other care providers on the day they were received. The GP who reviewed these documents and results was responsible for undertaking the action required. All staff we spoke with understood their roles and felt the system in place worked well.

We found appropriate end of life care arrangements were in place. The practice maintained a palliative care register. We saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider and the ambulance service.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice provided us with an example of good practice they had identified and shared through the CCG-wide Safeguard Incident Reporting Management System (SIRMS) to highlight it to other practices within the locality. This related to collaborative working between primary care and two hospital consultants to develop an emergency health care plan for a patient with complex needs. This example demonstrated a proactive approach on behalf of the practice to support a family where a number of family members had high levels of complex needs. The practice demonstrated they took a proactive, family orientated approach to meeting the needs of their local community.

The practice received a list of unplanned admissions and attendance at accident and emergency (A&E) to support them to monitor this area. These were discussed at weekly multi-disciplinary meetings. This helped to share important information about patients including those who were most vulnerable and high risk.

Information sharing

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

Electronic systems were in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times.

Consent to care and treatment

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

The GPs we spoke with showed they were knowledgeable about how and when to carry out Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's formal written consent was obtained. Verbal consent was taken from patients for the fitting of contraceptive implants and routine examinations. Patients we spoke with reported they felt involved in decisions about their care and treatment.

Health promotion and prevention

New patients were offered a 'new patient check'. The initial appointment was scheduled with one of the healthcare assistants, to ascertain details of their past medical histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g. smoking, alcohol intake, blood pressure, height and weight). The patient was then offered an appointment with a GP if there was a clinical need, for example, a review of medication.

Information on a range of topics and health promotion literature was available to patients in the waiting areas. This included information about screening services, smoking cessation and child health. Patients were encouraged to take an interest in their health and take action to improve and maintain it. The practice's website also provided links to other websites and information for patients on health promotion and prevention.

We found patients with long-term conditions were recalled to check on their health and review their medications for effectiveness. The practice's electronic system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. Staff told us this system worked well and prevented any patient groups from being overlooked. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening.

The practice offered a full range of immunisations for children, as well as travel and flu vaccinations, in line with current national guidance. MMR vaccination rates for five

Outstanding ☆

Are services effective?

(for example, treatment is effective)

year old children were 96.6% compared to an average of 98.3% in the local CCG area. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was in line with the national average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with 10 patients during our inspection. The majority were happy with the care they received. Although some of the patients we spoke with told us that one or two staff were abrupt or rude to them at times. Patients told us they were mostly treated with respect and were positive about the staff. Comments left by patients on the 59 CQC comment cards we received also reflected this. In particular, patients commented on the good service received in the diabetic clinic and the good listening skills and empathy demonstrated by GPs.

We looked at data from the National GP Patient Survey, published in January 2015. This demonstrated that patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. We saw that 94.2% (compared to 92.2% nationally) of patients said they had confidence and trust in their GP.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate, understanding and caring, while remaining respectful and professional. Many of the comments on the Care Quality Commission (CQC) comment cards referred to the helpful nature of staff. This was reflective of the results from the National GP Patient Survey where 93.9% of patients felt the reception staff were helpful, compared to a national average of 86.9%.

Patients' privacy, dignity and right to confidentiality were maintained. For example, the practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination. A private room or area was also made available when people wanted to talk in confidence with the reception staff. This reduced the risk of personal conversations being overheard.

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

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

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

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, the survey showed 78.1% of respondents said the GP was good at involving them in care decisions and 85.5% felt the GP was good at explaining treatment and results. Both these results were in line with the CCG area and national averages.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. The patient feedback on the 48 CQC comment cards we received was also positive and supported these views.

We saw that access to interpreting services was available to patients, should they require it. They said when a patient requested the use of an interpreter, staff could either book an interpreter to accompany the patient to their appointment or, if it was an immediate need, then a telephone service was available. There was also the facility to request translation of documents should it be necessary to provide written information for patients.

The practice did not have any easy read information to explain routine tests and treatments to patients with learning disabilities. They confirmed after the inspection they had sourced easy read materials they could use to support verbal explanations given to patients with learning disabilities. They had shared this with other practices in the local clinical commissioning group (CCG) area via the shared intranet system.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

We observed patients in the reception area being treated with kindness and compassion by staff. None of the patients we spoke with, or those who completed CQC comment cards, raised any concerns about the support they received to cope emotionally with their care and treatment.

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 84% of those surveyed thought the GPs they saw or spoke to was good at treating them with care and concern. Similarly, 79.4% thought nurses did. These were in line with local and England averages.

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

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

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

Support was provided to patients during times of bereavement. Families were offered a visit from a GP at these times for support and guidance. Staff were kept aware of patients who had been bereaved so they were prepared and ready to offer emotional support. The practice also offered details of bereavement services. Staff we spoke with in the practice recognised the importance of being sensitive to patients' wishes at these times. Feedback from patients on CQC comments supported this. One carer commented on the excellent coordination the practice had offered during end of life care, enabling a relative to die at home with dignity. Another commended the practice on the support they had received following the death of their spouse.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

Staff told us that where patients were known to have additional needs, such as being hard of hearing, were frail, or had a learning disability, this was noted on the medical system. This meant the GPs or nurses would already be aware of this and any additional support could be provided, for example, a longer appointment time.

The practice had arrangements in place to respond to the needs of patients with long term conditions. For example, the diabetes clinic delivered by the practice demonstrated a patient focussed approach.

Longer appointments were made available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the National GP Patient Survey published in January 2015 confirmed this. 87.3% of patients felt the doctor gave them enough time and 83.4% felt they had sufficient time with the nurse. These results were above the national averages (85.3% and 80.2% respectively).

Staff told us and we saw evidence of immediate phlebotomy appointments. (Phlebotomy is the surgical opening or puncture of a vein in order to withdraw blood.) Therefore patients were able to get their blood taken for testing on the same day the need for this was identified by the GP. This reduced delays in testing of blood samples and reduced the need for patients to make additional journeys to the practice or, for those who worked, or were in education during the day, to take time off to get a blood sample taken. Patient feedback in the CQC comment cards confirmed this facility was in place and working well.

The practice had a well-established Patient Participation Group (PPG). We spoke with three members of the group who said they felt the practice valued their contribution. The practice shared relevant information with the group and ensured their views were listened to and used to improve the service offered at the practice. For example, PPG members told us they had input into the opening hours of the practice over the Christmas period.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, opening times had been extended to provide evening appointments on Tuesdays and Thursdays. This helped to improve access for those patients who worked full-time or were in full time education.

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

The premises and services had been adapted to meet the needs of people with disabilities. All patient facilities were at ground floor level and there was wheelchair and step-free access. The practice did not have a hearing loop for patients who were hearing impaired. The practice manager told us they had not purchased one, as they had never been asked by a patient for this to be provided. Following the inspection the practice manager provided evidence that a hearing loop had now been purchased and was available for use by hearing impaired patients.

We saw that the waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice, including baby changing facilities.

The practice provided staff with equality and diversity training. Staff we spoke with confirmed that they had completed this training.

Access to the service

Consultations were provided face-to-face at the practice, over the telephone, or by means of a home visit by the GP.

Good

Are services responsive to people's needs?

(for example, to feedback?)

This helped to ensure patients had access to the right care at the right time. The National GP Patient Survey results showed that 84.7% of patients were satisfied with opening hours, compared to a national average of 75.7%.

Appointments were available on Monday to Friday 8.30am to 6.30pm, with late surgeries Tuesday and Thursday until 8.00pm for pre booked appointments.

A small number of the patients who filled in CQC comment cards were not as satisfied. They made comments such as 'The only complaint I have is with the system of booking appointments at 8am, which causes unnecessary stress' and 'Not always easy to get an appointment when needed'. We mentioned this to the practice manager and GPs, who said this feedback would be included as part of the ongoing review of the appointments system. All of the patients we spoke with did say they had been able to see a GP the same day if their need had been urgent.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Listening and learning from concerns and complaints

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

Staff we spoke with were aware of the practice's policy and knew how to respond in the event of a patient raising a complaint or concern with them directly.

The complaints policy was outlined in the practice leaflet. However, there was no information available for patients which signposted them to sources of additional support when making complaints such as local advocacy services or the Patient Advice and Liaison Service (PALS)

Of the 10 patients we spoke with, and the feedback we received from the 59 CQC comment cards completed by patients, none raised concerns about the practice's approach to complaints.

We looked at the summary of complaints that had been received in the 12 months prior to our inspection. We found these had been reviewed as part of the practice's formal annual review of complaints. Where mistakes had been made, it was noted the practice had apologised formally to patients and taken action to ensure they were not repeated. Complaints and lessons to be learned from them were discussed at staff meetings. Changes had been implemented where necessary. For instance, following a complaint about a missed B12 injection the practice considered the learning that could be identified and made changes to the way actions were recorded on correspondence from other healthcare professionals.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice did not have a separate business plan, but the strategy and business plans were set out over a number of documents relating to the management of the practice. These were reviewed regularly at clinical and partner meetings. It was evident in discussions we had with staff throughout the day that it was a shared vision and was fully embedded in staff's day-to-day practice. We found staff gave us a consistent response when we asked what the vision and strategy for the practice were. They told us there was a strong focus on being patient centred, and the practice achieved this by supporting good team working, professional development and training.

We spoke with 14 members of staff and they all knew the provision of high quality care for patients was the practice's main priority. They also knew what their responsibilities were in relation to this and how they played their part in delivering this for patients.

There was strong evidence throughout the practice that team spirit and motivation was high. Of particular note was the general feeling of 'all of us feel valued and of equal importance'. This was demonstrated from the moment you entered the practice as all staff photographs were displayed, including the domestic staff.

Governance arrangements

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

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

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

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

Leadership, openness and transparency

The practice had a clear leadership structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control and GP had leads in areas such as clinical governance, long-term conditions and training. We spoke with 14 members of staff and they were all clear about their own roles and responsibilities.

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

We found the practice leadership proactively drove continuous improvement and staff were accountable for delivering this.

There was a clear and positive approach to seeking out and embedding new ways of providing care and treatment. For example, the practice was investigating the reasons for patient attendance at Accident and Emergency Departments (A&E) where patients could have otherwise been seen at the practice to support the reduction of unnecessary A&E attendance. They were also taking action to optimise the use of medicines for patients. Arrangements in place supported the practice with improving quality.

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

Are services well-led?

Outstanding ☆

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

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

The practice had gathered feedback from patients through patient surveys, comments boxes and complaints received. The practice had a patient participation group (PPG). This was a virtual group and input was gathered by via email correspondence.

The practice manager showed us the analysis of the last patient survey they had carried out, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. Key priorities included increasing awareness of on-line services and awareness of the practice opening times and appointment availability. The practice published an annual report of the work carried out by the PPG and this was available on the practice website.

NHS England guidance states that from 1 December 2014, all GP practices must implement the NHS Friends and Family Test Survey (FFT). (The FFT Survey is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices). We saw the practice had recently introduced the FFT Survey. The practice had developed an application (App) for a touch screen tablet in conjunction with North Tyneside Clinical Commissioning Group (CCG). They had made this App available for other practices across the CCG. There were questionnaires available at the reception desk and instructions for patients on how to give feedback. The practice manager told us the comments and feedback would be reviewed regularly.

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions on a daily basis. There was a clear line of communication from GP Partners and the practice manager, through team leaders and onto all staff. Staff we spoke with told us they regularly received information about the practice and any proposed changes. They said they were provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they would not hesitate to raise any concerns they had.

Management lead through learning and improvement

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

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

We found there was a strong learning culture evident in the practice. This came across clearly through staff interviews, and was also evident in the approach to adopting and championing new initiatives and technology. The practice took a leading role in identifying new resources and sharing these with other practices across the locality. For example, the practice developed new policies and procedures and kept existing ones up to date and shared these with other local practices through the shared intranet facility. The practice actively shared those areas of innovation and good practice they identified with other local practices to help improve health services locally.