Earsdon Park Medical Practice

Quality Report

Shiremoor Resource Centre
Earsdon Road
Shiremoor
Newcastle Upon Tyne
Tyne and Wear
NE27 0HJ
Tel: 0191 2517139
Website: www.earsdonpark.co.uk

Date of inspection visit: 10 March 2015
Date of publication: 11/06/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Earsdon Park Medical Practice on 10 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for the following population groups: 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).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they were able to get an appointment with a GP when they needed one, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which they acted on.

We saw one area of outstanding practice:

Summary of findings

- Patients with learning disabilities were routinely offered appointments at times where they would not expect to have to wait long to be seen. For example first thing in the morning or at the start of a planned surgery session. This was in an attempt to meet these patient's specific needs and to reduce any reservations they may have had about attending the practice.

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

The provider should:

- Improve the systems used to record training completed by staff. The practice was aware of the need to do this. We saw an action plan was already in place to support the collation of copies of training certificates from staff and dates of training completed. The action plan should be followed through to completion.
- Endeavour to improve the quality of minutes produced from meetings held internally, in particular records of multidisciplinary meetings held.

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 report incidents and near misses. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There was enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring its effectiveness and had achieved 94% of the points available. This was slightly below than the local average of 96.8% but in line with the national average. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for staff. Staff worked with multidisciplinary teams which helped to provide effective care and treatment. The practice should endeavour to improve the quality of minutes produced from meetings held internally, in particular records of multidisciplinary meetings held. The clinical audits completed by the practice measured whether agreed standards had been achieved or made recommendations and took action where standards were not being met.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice in line with or above others for several aspects of care. For example, the survey showed 83% of practice respondents said the last GP they saw or spoke to involved them in decisions about their care and 81% said the last nurse they saw or spoke to involved them in decisions about their care. Both these results were higher than the local Clinical Commissioning Group (CCG) area and national averages. The CCG averages were 79% and 70%, with the national averages being 75% and 66% respectively. Patients said they were treated with compassion,

Summary of findings

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. They reviewed the needs of their local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Most patients said they found it easy to make an appointment with a GP, with urgent appointments available the same day. Patients with learning disabilities were offered appointments at times where they would not expect to have to wait long to be seen. For example first thing in the morning or at the start of a planned surgery session. This was in an attempt to meet these patient's specific needs and to reduce any reservations they may have had about attending the practice. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. They had 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. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which they acted on. The practice had a small patient participation group (PPG) and was looking to expand this. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. They offered proactive, personalised care to meet the needs of the older people in its population. For example, all patients over the age of 75 had a named GP and patients at high risk of hospital admission had care plans. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

The practice maintained a palliative care register and offered immunisations for pneumonia and shingles to older people.

People with long term conditions

Good

The practice is rated as good 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. Patients at high risk of hospital admission had structured reviews to check that their health and medication needs were being met. For those people with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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

The practice maintained a list of patients who had a new or on-going cancer diagnosis. A traffic light system was used to highlight those patients that required more intense input from the clinical team. The list was reviewed on a monthly basis and discussed at clinical meetings with the support of the Community Macmillan Nurse. Diabetic clinics were run once a month, alongside a dedicated diabetic dietician.

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. Childhood immunisation rates were in line with or

slightly above averages for the local Clinical Commissioning Group (CCG). For example, Infant Men C vaccination rates for two year old children were 97.0% compared to 97.5% across the CCG; and for five year old children were 96.6% compared to 92.9% across the CCG. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Cervical screening rates for women aged 25-64 were in line with the national average at 81%.

The practice routinely wrote to patients on turning 16 years old to advise them about services such as family planning and smoking cessation. Routine contraceptive and emergency sexual health care was provided. The practice were closely supported by the one-to-one centre in Shiremoor for a more extensive range of services, such as coil and implant fitting and more detailed sexual health checks.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible and flexible. The practice offered some online services as well as a full range of health promotion and screening which reflects the needs for this age group. GP appointments could be requested but not booked in advance online.

The practice offered extended opening hours on a Saturday morning between 8.00am and 10.30am. Patients could pre-book appointments to see a GP at these times. This made it easier for people of working age to get access to the service. They were hoping to be able to extend this provision further with early morning or weekday evening appointments in the future.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances, including those with a learning disability. They had carried out annual health checks for people with a learning disability. The practice offered longer appointments for people with a learning disability, if required. Patients with learning disabilities were offered appointments at times where they would not expect to have to wait

Summary of findings

long to be seen. For example first thing in the morning or at the start of a planned surgery session. This was in an attempt to meet these patient's specific needs and to reduce any reservations they may have had about attending the practice.

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

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They made vulnerable patients aware of how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. They carried out advance care planning for patients with dementia.

Patients with mental health diagnoses were offered opportunistic reviews at any point of contact. The practice had close links with the Community Mental Health Team (CMHT) in supporting changes to medicines prescribed and on-going reviews of care plans. Appointments, including daily telephone appointments, were available with the on call GP each day to allow time for contact with other services to support patients who were vulnerable, had poor mental health or long term conditions should they need a more multidisciplinary team approach to their on-going care.

The practice had sign-posted patients experiencing poor mental health to various support groups and organisations. Information and leaflets about services were made available to patients within the practice.

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What people who use the service say

We spoke with 20 patients in total across both of the branches of the practice. They were mostly complimentary about the services they received from the practice. They told us the staff who worked there were helpful and friendly. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were generally happy with the appointments system, although some patients were not as satisfied.

We reviewed 72 CQC comment cards completed by patients prior to the inspection. The large majority were complimentary about the practice, staff who worked there and the quality of service and care provided. Of the 72 CQC comment cards completed, 43 patients made direct reference to the caring manner of the practice staff. Words used to describe the approach of staff included helpful, polite, fantastic, caring, attentive, supportive, understanding and welcoming.

The latest National GP Patient Survey showed patients were mostly satisfied with the services the practice offered. The results were mainly in line with or better than other GP practices within the local Clinical Commissioning Group (CCG) area and nationally. The results were:

- The proportion of respondents who were able to get an appointment to see or speak to someone the last time they tried – 77% (CCG average 86%, national average 85%);
- The proportion of respondents who said the last GP they saw or spoke to was good at explaining tests and treatments – 91% (CCG 87%, national 82%);
- The proportion of respondents who said the last GP they saw or spoke to was good at involving them in decisions about their care – 83% (CCG 79%, national 75%);
- The proportion of respondents who said they had confidence and trust in the last GP they saw or spoke to – 95% (CCG 95%, national 92%);
- The proportion of respondents who said the last nurse they saw or spoke to was good at explaining tests and treatments – 86% (CCG 82%, national 77%);
- The proportion of respondents who said the last nurse they saw or spoke to was good at involving them in decisions about their care – 81% (CCG 70%, national 66%);
- The proportion of respondents who said they had confidence and trust in the last nurse they saw or spoke to – 96% (CCG 89%, national 86%).

These results were based on 120 surveys that were returned from a total of 365 sent out; a response rate of 33%.

Areas for improvement

Action the service SHOULD take to improve

The provider should:

- Improve the systems used to record training completed by staff. The practice was aware of the need to do this. We saw an action plan was already in place to support the collation of copies of training certificates from staff and dates of training completed. The action plan should be followed through to completion.
- Endeavour to improve the quality of minutes produced from meetings held internally, in particular records of multidisciplinary meetings held.

Outstanding practice

- Patients with learning disabilities were routinely offered appointments at times where they would not expect to have to wait long to be seen. For example

first thing in the morning or at the start of a planned surgery session. This was in an attempt to meet these patient's specific needs and to reduce any reservations they may have had about attending the practice.

Earsdon Park Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Earsdon Park Medical Practice

The practice is based within the Shiremoor Health Centre and also has a branch surgery at The Oxford Centre in Longbenton. The practice serves those living in Shiremoor, Longbenton and the surrounding areas. The practice provides services from the following addresses and these are where we carried out the inspection:

- Main surgery - Shiremoor Resource Centre, Earsdon Road, Shiremoor, Newcastle Upon Tyne, Tyne and Wear NE27 0HJ.
- Branch surgery - First Floor, Oxford Centre, West Farm Avenue, Longbenton, Newcastle upon Tyne, Tyne and Wear NE12 8LT.

The main surgery in Shiremoor provides all of its services to patients at ground floor level. Services at the branch surgery in Longbenton are provided from the first floor. The practice offers on-site parking at both sites including disabled parking bays, accessible WC's and step-free access. Two passenger lifts are available for patients to use at the Longbenton branch to access the first floor. The practice provides services to around 4,350 patients of all ages based on an Alternative Provider Medical Services (APMS) contract agreement for general practice. This is a locally negotiated contract open to both NHS practices and voluntary sector or private providers. The registered provider is Freeman Clinics Limited.

The practice has six GPs in total; two salaried GPs and four regular locum GPs. There is also one regular locum nurse practitioner, two practice nurses, one healthcare assistant, a practice manager and a team of administrative support staff. At the time of the inspection there was no registered manager in post, however the provider was aware of and taking steps to address this.

The CQC intelligent monitoring system placed the area in which the practice was located in the fifth more deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The practice's age distribution profile showed slightly higher percentages of children aged 0-4 years and female patients aged 30-39 years than the national averages.

The service for patients requiring urgent medical attention out-of-hours is provided by the 111 service and Northern Doctors Urgent Care Limited.

Why we carried out this inspection

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

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.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the Care Quality Commission at that time.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice. This highlighted one area for follow-up which can be found within the 'effective' key question. We also asked other organisations to share what they knew. This included the local Clinical Commissioning Group (CCG).

We carried out an announced visit on 10 March 2015. We visited the practice's main surgery in Shiremoor and the branch surgery in Longbenton. We spoke with 20 patients and a range of staff from the practice. We spoke with the practice manager, three GPs, two practice nurses, a health care assistant and some of the practice's administrative and support staff. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 72 CQC comment cards where patients from the main and branch surgeries 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

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.

As part of our planning we looked at a range of information available about the practice. This included information from the latest GP Patient Survey results published in January 2015 and the Quality and Outcomes Framework (QOF) results for 2013/14. The latest information available to us indicated there were no areas of concern in relation to patient safety.

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety. For example, an incident had been recorded where the potential for medication fraud had been identified. This was discussed at a practice meeting and as a result GPs had changed their practise with regards to medication requests from patients who had recently registered with the practice.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could demonstrate a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw records were kept of significant events that had occurred. There had been 12 events recorded during the last 12 months and we looked at the records of these. Significant events were discussed at practice and clinical sub-group meetings attended by GPs, nurses and others who were involved. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff, were aware of the system for raising significant events and said they felt encouraged to do so.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who managed and monitored them. We saw evidence of action taken as a result, for example internal guidance on urine testing had been reviewed. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken.

National patient safety alerts were received into the practice electronically by the practice manager. The alerts were reviewed and sent to the appropriate staff for their attention. Staff we spoke with were aware of these systems and were able to give examples of recent alerts relevant to the care they were responsible for. Staff said alerts were also discussed at meetings to ensure they were aware of any relevant to their area of work and where action needed to be taken. The practice manager said copies of relevant alerts were placed in the practice's locum GP pack; however when we looked at the locum GP pack, no alerts could be found.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out-of-hours. We saw contact details were easily accessible.

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

Good

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, 'looked after children' were coded on the system.

A chaperone policy was in place and notices were displayed in the patient waiting areas to inform them of their right to request one. Clinical staff and a small number of trained administrative staff carried out chaperoning duties when patients requested this service. Non-clinical staff that carried out chaperone duties had either undergone a Disclosure and Barring Service (DBS) criminal record check or been risk assessed for the 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

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.

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. One of the emergency medicines (Adrenaline) kept at the Longbenton Branch was in a box that suggested the expiry date was June 2014, however the medicine inside the box had an expiry date of March 2015 and was still safe to use. There was a small risk however, that if this medicine was needed in an emergency, the member of staff may hesitate to use it due to the expiry date displayed on the packaging.

We saw records of meetings held with the GPs and practice pharmacist that noted the actions taken in response to reviews of prescribing data. For example, patterns of antibiotic had been reviewed and short term prescribing of a specific antibiotic medicine was below the local Clinical Commissioning Group (CCG) average.

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

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw blank prescription forms were stored securely. The arrangements were in line with best practice guidance issued by NHS Protect.

Cleanliness & Infection Control

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

The practice had a nurse who led for infection control and they were supported by another nurse and a member of the administrative support staff. All staff received induction training about infection control specific to their role, and thereafter updates were provided internally or at 'Time-Out' training sessions.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement infection control measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. Staff who worked on reception were able to describe the process to follow for the receipt of patient specimens. There was also a policy for needle stick injuries and the disposal and management of clinical waste.

Hand hygiene techniques signage was displayed throughout the practice. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Not all of the treatment and consultation rooms had flooring that was impermeable, however all flooring was visibly clean. Spillage kits were available at the main and branch surgeries to deal with any biological fluid spills.

Good

Are services safe?

The practice had processes in place for the management, testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings). We saw the practice was carrying out regular checks in line with this to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw evidence of calibration of relevant equipment; for example, weighing scales and blood pressure monitoring equipment. Two items of equipment that had failed calibration testing had been disposed of and replaced.

All portable electrical equipment at the main surgery in Shiremoor had last been tested in 2008/09, whereas electrical equipment at the Longbenton branch had been tested recently. The practice manager said they had been waiting for the landlords of the Shiremoor building to complete the portable appliance testing (PAT); however the practice would now look to organise this themselves.

Staffing & 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 an appropriate professional body and criminal record checks via the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards they followed when recruiting staff.

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There were arrangements in place for members of staff to cover each other's annual leave. The practice now used four regular locum GPs which had helped to provide greater continuity of care for their patients.

Staff told us there was enough staff to maintain the smooth running of the practice and there was always enough staff on duty to ensure patients were kept safe. We saw records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff and patients to see.

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

Staff were able to identify and respond to changing risks to patients, including deteriorating health and medical emergencies. For example, staff who worked in the practice were trained in cardiopulmonary resuscitation (CPR) and basic life support skills.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing staff had received training in basic life support. Emergency equipment was available. This included a defibrillator (used to attempt to restart a person's heart in an emergency) and oxygen. The defibrillator at the main surgery in Shiremoor was shared between the three GP practices based there and was kept in the reception area of the building. Records of daily checks of the defibrillator and monthly checks of the oxygen were up-to-date. All the staff we asked knew the location of this equipment.

Emergency medicines were available in a secure area of the practice and all the staff we spoke with knew of their location. Medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Good

Are services safe?

A well-structured and detailed business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure and loss of access to the building. It also included a detailed list of contacts and a flow chart of actions to be taken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could describe the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE). We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs and these were reviewed when appropriate. For example, a GP we spoke with said patient's prescribed high risk medicines commonly known as disease-modifying anti-rheumatic drugs (DMARDs) were recalled for review every three months.

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

Patients we spoke with said they felt well supported by the GPs and clinical staff with regards to decision making and choices about their treatment. This was reflected in the comments left by patients who completed CQC comment cards.

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

Management, monitoring and improving outcomes for people

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

The practice were able to show us some clinical audits that had been completed. We looked at two examples of clinical audits that had been undertaken in the last few years. The audits included repeat audit cycles, where the practice was able to demonstrate the changes resulting since the initial audits had been carried out. For example, the practice had completed and audit on the prescribing of one type medicine in combination with another type of medicine for patients over 45 years of age. The aim of the audit was to ensure the practice was following NICE guidelines and to identify where any such prescribing could be improved. The first audit demonstrated that 80.34% of the patients identified as at increased risk of adverse side effects from one medicine were having the other medicine co-prescribed as per the guidance. The information was shared at a practice meeting and clinical staff were reminded of the guidance to be followed. A second clinical audit was completed six months later which demonstrated that 83.93% of the patients identified were now having both medicines prescribed as per the guidance. This was an improvement with respect to the standard setting and a reduction in the number of patients on repeat prescriptions was also noted.

The practice was proactive in the management, monitoring and improving of outcomes for patients. For example, they used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. The Quality and Outcomes Framework is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually. The practice had achieved 94% of the points available in 2013/14, which included all of the points available for asthma and epilepsy. Data that we reviewed before the inspection showed in 2013/14 the practice was below the national average for recording whether their patients with schizophrenia, bipolar affective disorder and other psychoses had a record of alcohol consumption in the preceding 12 months. We spoke with the clinical lead about it, who said they were aware of this. They said the practice was working with a specialist nurse and community psychiatric nurse (CPN) to improve this. These patients received an annual review with the community mental health team.

Good

Are services effective?

(for example, treatment is effective)

The practice also had a number of improvement plans in place. For example, the practice had had some problems with the recruitment of GPs in the past. This had meant patients had not always had the opportunity to see the same doctor on a regular basis. In response to this, the practice had secured the services of a number of long term locum GPs with a view to them becoming salaried GPs at the practice. This had resulted in improvements in the continuity of care the practice was able to provide for its patients. A number of the patients we spoke with commented on how this situation had improved over recent months.

The practice manager showed us their 'Provider Quarterly Performance Report' that they updated and submitted to NHS England every three months as part of their contract monitoring process. As well as reporting on performance, the practice used the report to identify areas for improvement in the services they provided. For example, the information collated showed the practice had increased the number of eligible, registered female patients who had attended for cervical screening from 69.98% at the start of 2014/15 to 92.36% by the end of quarter three of 2014/15. Other aspects of the service that were monitored in this way included childhood immunisations, value for money prescribing and patient satisfaction.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records with the practice manager. We found some of the evidence of training completed by staff was inconsistent. The practice were aware of this and we saw an action plan was already in place to support the collation of copies of training certificates from staff and dates of training completed. Mandatory training was being monitored and updated. Staff had either completed CPR and basic life support training or were booked to attend in the next few weeks. 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 undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list.)

All staff undertook annual appraisals which identified learning needs from which action plans were documented. We saw records in staff files of appraisals completed since July 2014. Staff interviews confirmed that the practice was supportive in providing training and funding for relevant courses. For example, nurses were encouraged to attend training events and GPs were allocated time for continuing professional development (CPD) as part of their timetable.

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.

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

Working with colleagues and other services

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

GPs told us they worked well together as a team. For example, the long term locum GPs who worked at the practice were actively involved with daily tasks such as the review of correspondence received into the practice. This helped to manage the demands placed upon the salaried GPs and promoted positive working relationships.

The practice held multidisciplinary team (MDT) meetings on a monthly basis to discuss the needs of high risk patients, for example, those with end of life care needs. The practice staff involved said these meetings could be minuted more effectively. These meetings were attended by a range of healthcare professionals, including district nurses, community matrons and palliative care nurses, and decisions about care planning were recorded. The

Good

Are services effective?

(for example, treatment is effective)

practice's GPs attended these meetings and felt this system worked well. They remarked on the usefulness of the meetings as a means of sharing important information. The practice maintained a list of patients who had a new or ongoing cancer diagnosis. A 'traffic light system' was used for these patients to indicate those that required more intense input from the clinical team. The list was reviewed and discussed at the MDT meetings.

Information Sharing

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

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. Training had been completed, both internally via e-learning and externally at the quarterly 'Time Out' training days run by the local Clinical Commissioning Group (CCG). All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. They also demonstrated an understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for 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 routine examinations. Patients we spoke with reported they felt involved in decisions about their care and treatment. We saw one of the GPs had developed their own information leaflet for patients who had been offered soft tissue or joint injections to help reduce inflammation. This included the risks and benefits of the procedure and confirmed the process for obtaining verbal and written consent from patients.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. Staff we spoke with gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

Health Promotion & Prevention

The practice offered new patients a health check with a member of the healthcare team. This was to ensure that any required tests were up to date and that the practice had an accurate record of any repeat medication being taken. The patient's needs were assessed and where appropriate, they were placed into the relevant monitoring service. For example, patients with long term conditions would be added to the appropriate registers.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance (2013/14) for immunisations was in line with or slightly above averages for the local Clinical Commissioning Group (CCG). For example, Infant Men C vaccination rates for two year old children were 97.0% compared to 97.5% across the CCG; and for five year old children were 96.6% compared to 92.9% across the CCG.

We found patients with long-term conditions were recalled to check on their health and review their medicines for effectiveness. The practice's electronic system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. We were told this worked well to prevent any patient groups from being overlooked. Processes were also in place to ensure the regular screening of patients was completed, for example, cervical screening. Performance in this area for 2013/14 was in line with the national average at 81%.

There was a range of information on display within the practice reception area. This included a number of health promotion and prevention leaflets, for example on cancer,

Good

Are services effective?

(for example, treatment is effective)

self-care, breast feeding and dementia support services. The practice's website included links to a range of patient information, including for family health, long term conditions and minor illnesses.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with said they were treated with respect and dignity by the practice staff. Comments left by patients on Care Quality Commission (CQC) comment cards mostly reflected this. Of the 72 CQC comment cards completed, 43 patients made direct reference to the caring manner of the practice staff. Words used to describe the approach of staff included helpful, polite, fantastic, caring, attentive, supportive, understanding and welcoming.

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

The reception areas at both the main and branch surgeries fronted directly onto the patient waiting areas. We saw staff who worked in these areas made every effort to maintain patients' privacy and confidentiality. Voices were lowered and personal information was only discussed when absolutely necessary. Phone calls from patients and other healthcare professionals were taken by administrative staff in an area where confidentiality could be maintained.

Patients' privacy, dignity and right to confidentiality were maintained. For example, the practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination. Staff we spoke with at both surgeries said a spare room was made available for patients to use if they wanted to speak about matters in private. This reduced the risk of personal conversations being overheard.

Staff were aware of the need to keep records secure. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation. Staff had completed information governance training, with some due to update this in the next few weeks.

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 83% of practice respondents said the last GP they saw or spoke to involved them in decisions about their care and 81% said the last nurse they saw or spoke to involved them in decisions about their care. Both these results were higher than the local Clinical Commissioning Group (CCG) area and national averages. The CCG averages were 79% and 70%, with the national averages being 75% and 66% respectively.

The majority of the most recently published National GP Patient Survey results for the practice were a little above the local CCG area and national averages. For example, 92% of respondents said the last GP they saw or spoke to was good at listening to them and 86% of respondents reported the same for the last nurse they saw or spoke to. The CCG averages were 92% and 83%, with the national averages being 87% and 79% respectively. The practice had also scored well in terms of patients feeling they had confidence and trust in the last GP (95% of respondents) or nurse (96%) they saw or spoke to. This compared to the CCG averages of 95% and 89%, with the national averages being 92% and 86% respectively.

Feedback from patients we spoke with reflected the results from the latest National GP Patient Survey. They told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also said they felt listened to and supported by staff and felt they had sufficient time during consultations to make informed decisions about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and supported these views.

The practice had identified its most at risk and vulnerable patients. They had not signed up to the enhanced service for 'Avoiding Unplanned Hospital Admissions', however they were still completing the work associated with this service. Enhanced Services are services which require an enhanced level of service provision beyond their contractual obligations, for which they receive additional payments. A number of patients had been identified as

Good

Are services caring?

being at high risk of hospital admission. The practice had contacted these patients and with their involvement and agreement, had put agreed plans of care in place. For example, plans that had been put into place for a number of at risk patients were described to us by the GPs we spoke with.

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

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice and rated it well in this area. The CQC comment cards we received were also consistent with this feedback. For example, patients commented the GPs and staff knew them well and were caring and supportive.

Notices in the patient waiting room signposted patients to a number of support groups and organisations. The practice website included information to support its patients. For example, information was provided for patients who had caring responsibilities or who were cared for by a family member or friend. The practice maintained a carer's register and had 45 patients on the register. We were told all of these patients received an annual health check. They were proactive in trying to identify patients with caring responsibilities. Patients who registered with the practice were asked if they had any caring responsibilities.

Support was provided to patients during times of need, such as in the event of bereavement. Telephone calls were made to bereaved relatives (if appropriate) at these times to offer support and guidance. Staff we spoke with in the practice recognised the importance of being sensitive to patients' wishes at these times. The practice had also developed links with 'Relate' (a registered charity who provide relationship counselling services) at their Longbenton site and could signpost their patients to them for advice and support in times of need. They also supported social prescribing schemes, including schemes that provided activities for engaging with patients who had suffered personal loss.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients we spoke with and those who filled out Care Quality Commission (CQC) comment cards said they felt the practice was meeting their needs. This included being able to access repeat medicines at short notice when this was required.

The practice engaged regularly with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. The clinical lead GP attended CCG meetings as part of the 'practice activity scheme'.

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Staff we spoke with said patients were encouraged to see the same GP if possible, which enabled good continuity of care. The salaried GPs we spoke with said this had been difficult to achieve in the past, however the use of long term locum GPs had delivered improved continuity of care for their patients. The patients we spoke with supported this view. Patients could access appointments face-to-face in the practice, receive a telephone consultation with a GP or nurse or be visited at home. Longer appointments were available for people who needed them. The practice had identified their patients with learning disabilities and this was flagged on their individual patient records. Staff we spoke with said these patients were offered appointments at times where they would not expect to have to wait long to be seen. For example first thing in the morning or at the start of a planned surgery session. This was in an attempt to meet these patient's specific needs and to reduce any reservations they may have had about attending the practice.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients and their families' care and support needs. The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment.

The practice had a patient participation group (PPG) and met with them on a bi-monthly basis. We spoke with two members of the group ahead of the inspection. They said the group was quite small, however they were actively looking to expands its membership beyond the current level of three patients. An open day had been held in the practice in the last week for this purpose and a number of patients had registered an interest. They said feedback from the group was well received by the practice and a number of changes had been made by them in response to patient feedback. For example, some patients had asked for the opening times of the practice and the telephone lines to be synchronised. They had responded to this, with both now opening at 8.00am.

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 Saturday morning appointments with one of two GPs on duty at that time. This helped to improve access for those patients who worked full time. The practice also had access to telephone translation services if required, for those patients whose first language was not English. The practice maintained registers for patients with caring responsibilities, patients with learning disabilities and patients receiving palliative care. All of these measures helped to ensure that all of their patients had equal opportunities to access the care, treatment and support they needed.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Most of the patients we spoke with and those who filled out Care Quality Commission (CQC) comment cards said they were satisfied with the appointment systems operated by the practice. Comments included always able to get an appointment, appointments fairly easy and can usually get an appointment when needed. A small number of the patients who filled in CQC comment cards were not as satisfied. They made comments such as too long to get an appointment with my normal doctor and too long to get appointment if it is not urgent. 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.

The latest results from the National GP Patient Survey published in January 2015 were mixed in terms of patient's feedback regarding appointments. 77% of respondents said they were able to get an appointment to see or speak to someone the last time they tried. This was below both the local Clinical Commissioning Group (86%) and national (85%) averages. In contrast, the practice had achieved better than local and national average results from patients on their experience of making an appointment and the convenience of their last appointment. 78% of respondents said their experience of making an appointment was good (compared to the CCG average 78%, national average 74%) and 96% said their last appointment was convenient (compared to the CCG average 93%, national average 92%).

We looked at the practice's appointments system in real-time at 2pm on the day of the inspection. At that time, four appointments were still available to be booked with a GP that day, in addition to telephone triage appointments. Routine appointments to see a GP were available to be booked within three days. The practice offered a nurse-led telephone triage system to prioritise the allocation of on the day appointments. This service had been set up to enable contact at numerous points throughout the day. The practice was supported by a paediatric nurse led walk in clinic for patients with young children who wanted to be seen urgently. The practice also facilitated the review of patients from this clinic who were felt to need a GP review that day.

The practice was open from 8.00am to 6.30pm Monday to Friday and from 8.00am to 10.30am on Saturday mornings. The practice's extended opening hours on Saturday's were particularly useful to patients with work commitments. This was confirmed by patients we spoke with who normally worked during the week. The practice was hoping to be in a position to extend this provision further with early morning or weekday evening appointments in the future.

Longer appointments were available for patients who needed them. This also included appointments with a GP or nurse. Home visits were made to those patients who were unable to attend either of the practice's surgeries. One of the salaried GPs we spoke with said they had completed home visits late in the day beyond their contractual hours, rather than pass this responsibility on to the out of hour's service provider.

Information was available to patients about appointments on the practice website. The practice did not offer the facility for patients to book appointments with GPs online. Patients could however submit a request for an appointment or telephone consultation online. When an appointment or call had been booked, an email reply was sent to the patient with the details. Information on how to arrange home visits was provided for patients on the website.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The service for patients requiring urgent medical attention out-of-hours was provided by the 111 service and Northern Doctors Urgent Care Limited.

Listening and learning from concerns & complaints

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

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

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.

One of the patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice before. They said the practice manager had offered to call them to discuss their complaint. In addition, only one of the 72 CQC comment cards completed by patients indicated they had raised a complaint with the practice. The patient who completed the card commented it had been resolved to their satisfaction and things had improved since.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice's aims and objectives were to provide its patients with the highest standard of personal health care and to seek continuous improvement in the health of their patients. This was reflected in the practice's statement of purpose, along with a number of other aims including being courteous, approachable and friendly and treating all patients and staff with dignity, respect and honesty.

We spoke with a variety of practice staff including the practice manager, GPs, nurses, a health care assistant and some of the practice's administrative and support staff. They all knew and shared the practice's aims and objectives and knew what their responsibilities were in relation to these. Staff regularly spoke of working towards the same aim – making sure patients got the best care possible.

Governance Arrangements

The practice had policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked a sample of these policies and procedures and our discussions with staff demonstrated they had read and understood these. All of the policies and procedures we looked at had been reviewed regularly and were up to date.

The practice used the Quality and Outcomes Framework (QOF) as a means to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at practice meetings and actions were taken to maintain or improve outcomes. For example, reminders were sent to patients if they failed to respond to requests to attend the practice for reviews of their long-term conditions.

The practice had completed a number of clinical audits which it used to monitor quality and systems to identify where action should be taken. The clinical audits completed measured whether agreed standards had been achieved or made recommendations and took action where standards were not being met. A GP we spoke with said the results of completed audits were presented to and discussed with their colleagues at meetings.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a range of potential issues. We saw that risks were regularly discussed at practice meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and actions to mitigate these risks had been put into place.

The practice held regular meetings for clinical staff, management and the administrative team. We looked at minutes from some of these meetings and found that performance, quality and risks had been discussed. Staff we spoke with commented on the fact that the recording of minutes of meetings was an area they felt the practice could improve upon.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, there were lead nurses for infection control and a salaried GP was the lead for safeguarding. We spoke with a range of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We found there were good levels of staff satisfaction. Staff we spoke with were proud of the organisation as a place to work and spoke of the open and honest culture. There were good levels of staff engagement. We saw from minutes that team meetings were held regularly. Staff told us they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for the application of the provider's human resource policies and procedures. We reviewed a number of policies, for example on health and safety and prescribing, which were in place to support staff. We saw policies were available for all staff to access electronically. Staff we spoke with knew where to find the practice's policies if required.

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

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions on a daily basis. Staff we spoke with told us they regularly attended staff meetings, including within their own work areas and wider practice meetings. They said these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and

Are services well-led?

Good

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

management. We saw the practice also used the meetings to share information about any changes or action they were taking to improve the service and they actively encouraged staff to discuss these points. Staff told us they felt involved in the practice to improve outcomes for both staff and patients.

The staff we spoke with, including the practice manager and GPs told us forward planning was discussed. We saw plans were in place to develop and improve the services provided. For example, the practice were looking to increase the size of the clinical team employed to reduce their reliance on locum arrangements. Staff said they felt listened to and their opinions were valued and contributed to shaping and improving the service.

The practice had a patient participation group (PPG). The PPG had a small number of members; however the practice had recently held an open day in an attempt to increase the size of the group. A number of patients had registered their interest and the practice were hoping to increase the number and diversity of patients within the group. The PPG met bi-monthly and representatives from the practice always attended to support the group. We spoke with some members of the PPG and they felt the practice supported them fully with their work and took on board and reacted to any concerns they raised. For example, the practice had made some changes as a result of feedback from the PPG. This included synchronising the opening time of the practice with the time the telephone lines opened. Patient feedback was also routinely reviewed at group meetings, including any actions taken by the practice in response.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they wouldn't hesitate to raise any concerns they had. Staff said significant events were handled consistently, which helped to create a culture of dealing positively with circumstances when things went wrong.

Management lead through learning & improvement

Staff said that the practice supported them to maintain their clinical professional development through training and mentoring. We saw that appraisals took place which included a personal development plan. Staff told us that the practice was supportive of training and development opportunities.

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

The clinical lead GP showed us they had recently introduced a clinical newsletter to try and update all of the practice's GPs on where to find information and current clinical updates. For example, the newsletter we saw included information on protocols, referrals, acute access, QOF and safeguarding. The intention was to share learning and encourage the discussion of clinical matters within the practice.

The practice manager met regularly with other practice managers in the area and shared learning and experiences from these meetings with colleagues. GPs met with colleagues at locality and Clinical Commissioning Group (CCG) meetings. They attended learning events and shared information from these with the other GPs in the practice. Nursing staff we spoke with said they had attended a monthly CCG wide practice nurse forum which provided them with further education and support.

Information and learning was shared verbally between staff and the practice also used their intranet system to store and share information. Learning needs were identified through the appraisal process and staff were supported with their development. For example, one of the administrative team had asked for some formal training relevant to their position and the practice was supporting and providing them with that.