St Anthony's Health Centre

Quality Report

St Anthony's Health Centre, St. Anthony's Road,Tyne and Wear, Newcastle Upon Tyne,
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St Anthony's Health Centre on 17 February 2015.

Overall the practice was rated as good. The practice provided outstanding care for people whose circumstances may make them vulnerable.

Our key findings 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.
- People's 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 training planned.
- The practice had a strong community awareness and understood that some health outcomes were best improved by working with local people to help them improve their own health. The practice encouraged patients to improve their own health, and had supported practice Health Champions. Successful initiatives included a walking group, guided cycle rides for over 50s and a patient choir.
- The practice had a proactive approach to regularly identify, review and plan how they met the needs of all identified vulnerable patients. This included those patients whose needs might not otherwise be considered at other multidisciplinary meetings. This helped ensure they planned for and were meeting the needs of their vulnerable patients.
- The practice had systems in place for completing clinical audit cycles to review and improve patient care.
- 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.
- 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 upon.

Summary of findings

- The practice had been visited by a team from Skills for People to learn how they could improve the way they met the needs of patients with learning disabilities. They had acted upon the recommendations made.

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. Lessons were learned and communicated widely to support improvement. The practice had regular weekly multidisciplinary meetings to discuss the safeguarding of vulnerable patients. This was supported by a six monthly review of the needs of all vulnerable adults to ensure the practice continued to meet the needs of these patients. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good 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 was performing highly when compared to neighbouring practices in the CCG. The practice was using innovative and proactive methods to improve patient outcomes. We found the practice was supporting people to live healthier lives through health promotion and prevention of ill health.

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 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. They 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. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent

Summary of findings

appointments available the same day. 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 and other stakeholders.

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. 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. The practice offered proactive, personalised care to meet the needs of the older people in their population and had a range of enhanced services, for example, in dementia and end of life care. They 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

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. These patients had a named GP and a structured annual review to check that their health and medication needs were being met. 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 relatively high for all standard childhood immunisations. 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, health visitors and school nurses.

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.

Summary of findings

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had a proactive approach to regularly identify, review and plan how they met the needs of all identified vulnerable patients.

The practice had been visited by a team from Skills for People to learn how they could improve the way they met the needs of patients with learning disabilities. They had acted upon the recommendations made.

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.

They had told vulnerable patients about 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.

The practice had strong community awareness and understood that some health outcomes were best improved by working with local people to help them improve their own health. The practice had considered local health inequalities and had implemented several innovative initiatives to help patients improve their own health. In particular, these focussed on the needs of patients who may have poor access to primary care.

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 four patients during the inspection. This included two patient Health Champions, who were also members of the Patient Participation Group (PPG).

Patients told us staff were polite, courteous and approachable, and treated them with dignity and respect. Also, 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.

The patients we spoke with told us they would recommend the practice to family and friends.

We reviewed 33 CQC comment cards completed by patients prior to the inspection. Patients commented positively on staff being considerate, caring, polite and helpful, taking action when needed and the practice being clean and safe. Two comment cards included concerns, but no key themes were identified.

The latest GP Patient Survey completed in 2014 showed the majority of patients were satisfied with the services the practice offered. Most of the indicators below were above or in line with National averages.

- 98.2% described their overall experience of this surgery as good (national average 85.7%)
- 95.8% would recommend this surgery to someone new to the area (national average 78.7%)
- 95.7% were satisfied with the surgery's opening hours (national average 76.9%)
- 96.8% said the last appointment they got was convenient (national average 91.9%)
- 78.5% said it was easy to get through to someone at the GP practice on the phone (national average 72.9%)
- 87.0% said they were able to get an appointment to see or speak with someone (national average 85.7%)

These results were based on 94 surveys that were returned from a total of 400 sent out; a response rate of 24%.

St Anthony's Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector. The team included a GP and an additional CQC inspector.

Background to St Anthony's Health Centre

St Anthony's Health Centre is based in the Walker area of Newcastle Upon Tyne. The practice provides services to around 6,000 patients from St Anthony's Health Centre, St. Anthony's Road, Tyne and Wear, Newcastle Upon Tyne, NE6 2NN.

The practice is based in a purpose built building. All patient facilities are on the ground floor. There is a disabled WC, wheelchair and step-free access. Street parking is available nearby.

The practice has five GP partners, a salaried GP, two practice nurses, a healthcare assistant, a practice manager and staff who carry out reception and administrative duties. There are both male and female clinicians at the practice.

Surgery opening times are 8.30am - 6.00pm weekdays and a Saturday morning surgery between 8:30am and 11:30am for patients with pre-booked appointments.

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

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

The practice population age distribution follows a similar pattern to the national average, with the majority of patients within the 20 to 55 age range. The average male life expectancy is 78 years (national average 79 years) and the average female life expectancy is 81 (national average 83 years). The percentage of patients with long term conditions is in line with the national average at 54.1% (compared to a national average of 54%). There is a higher percentage with health-related problems in daily life (68.4% compared to 48.8% nationally). There are a lower number reporting caring responsibilities at 11.4% compared to 18.2% nationally.

Why we carried out this inspection

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

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

Detailed findings

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

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

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. This did not highlight any significant areas of risk across the five key question areas. As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local Clinical Commissioning Group (CCG).

We carried out an announced visit on 17 February 2015. We spoke with four patients and nine members of staff. We spoke with two partner GPs, a salaried doctor, the practice manager, a member of the nursing team, a nursing assistant, and three reception and administration staff. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 33 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.

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.

Good

Are services safe?

Our findings

Safe track record

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.

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.

For example, a significant event relating to young child prescribed an incorrect dose of medication was fully investigated. Immediate action was taken to rectify the problem and an apology was given to the child's parent. An audit was undertaken on all children who were prescribed this medication to check if any other patients' medicine dosage was incorrect. Learning identified was also shared with the relevant paediatrician to reduce the risk of a similar error occurring in the future.

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 on the practice meeting agenda. GPs and other staff could also discuss significant events during a half hour get together each day. This allowed timely action and follow up. 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 and other organisations as appropriate. 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 used incident forms on the practice intranet and sent completed forms to the practice manager. We tracked two of the 11 incidents over the last year and saw records were completed in a comprehensive and timely manner. Where follow up action was identified, we saw that accountabilities were identified and a priority and timescale given.

Where incidents and events meet threshold criteria, these were also added to the Newcastle North and East Clinical Commissioning Group Safeguard Incident & Risk Management System (SIRMS). This allowed the practice to contribute to and benefit from learning identified from incidents across the local area and also to share information where more than one organisation was involved.

We saw evidence of action taken as a result of significant events. For example, following a missed ectopic pregnancy, the practice changed the type of pregnancy test used to one with increased sensitivity to reduce the risk of a similar event happening. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

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

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 discussed weekly and 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.

Good

Are services safe?

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 the higher level of training for safeguarding children (Level 3). 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, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible on the practice intranet.

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 subject to child protection plans were clearly flagged and reviewed. There were weekly multi-disciplinary meetings to discuss the safeguarding of patients.

The practice also had systems to monitor babies and children who failed to attend for health checks, childhood immunisations, or who had high levels of attendances at accident and emergency departments (A&E).

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). We saw this was also advertised in the waiting room and consulting rooms. Clinical staff, such as practice nurses, acted as a chaperone.

Medicines management

We found the practice had in place good arrangements for the management of medicines. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

Maximum and minimum temperatures of the refrigerator were checked and recorded every day when the surgery was open. This ensured that the vaccines were fit for use. Vaccines were administered by practice nurses using directions that had been produced in line with legal requirements and national guidance.

Blank prescription forms were handled in accordance with national guidance and were kept securely. Although the prescriptions were kept in a locked room, they were not kept in a locked cupboard. The practice manager said they would address this immediately following the inspection. All prescriptions were reviewed and signed by a GP before they were given to the patient. There were safe procedures in place to issue repeat prescriptions. Some prescriptions were collected by local pharmacies. The practice had implemented a procedure to reduce the risk of errors or misplacement of prescriptions being collected by local pharmacies.

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. The practice published an annual infection control statement on their website. We viewed this and saw that it detailed who led on infection control, the infection control training delivered to staff, what audits were carried out, the date policies and procedures relating to infection control had been reviewed

and the areas these covered. It also stated whether any serious incidents relating to infection control had been identified. We saw that for 2014-15 no incidents had occurred.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. There was also a policy for needle stick injury. There were contracts in place for the collection of both general and clinical waste.

The risk of the spread of inspection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. Both treatment rooms had walls and flooring that was easy to clean. Hand washing instructions were displayed by hand basins and there was a supply of liquid soap and paper hand towels. The privacy curtains in the consultation rooms were disposable and had the date on them when they were last changed. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. There were sharps disposal boxes in all the clinical areas of the practice. These were signed and dated on construction to provide an auditable trail. Cleaning kits for dealing with spillage of bodily fluids were available in the reception area.

The practice had undertaken monthly audits of infection control arrangements. An infection control audit helps practices identify areas to improve and potential infection risks. We saw the most recent example of this. Where improvements were identified, an action plan was put in place and we saw evidence action was taken as a result.

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 annual updates.

Staff told us they had received training recently in infection control procedures, including handling specimens and hand washing. Staff records confirmed this had taken place.

The practice manager told us they had arranged training with the cleaning company contracted with the practice in infection control procedures. We saw evidence to confirm this.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. The practice was in the process of arranging for electrical equipment to be retested. A schedule of testing was in place. We saw that where required, equipment was calibrated (adjusted for accuracy) in line with manufacturer's guidelines. For example, weighing scales and blood pressure monitoring equipment.

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 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.

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. Staff told us there were effective arrangements for planning and monitoring the number of staff 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 within their competence level in the practice which were particularly busy. For example, within the reception on the front desk receiving patients or on the telephones.

Good

Are services safe?

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to 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.

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 a fire and a health and safety risk assessment. Risk assessments of this type helped to ensure the practice was aware of any potential risks to patients, staff and visitors and was able to plan mitigating action to reduce the probability of harm. The practice had contracted an external company to provide advice in relation to managing health and safety risks for staff, patients and visitors. As a result the practice planned to implement health and safety method statements to provide more person centred risk assessments. A method statement sets out the way a work task or process is completed and outlines the hazards involved and the step by step guide as to how individuals can do this safely.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to emergency medicines, oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with knew the location of this equipment.

Emergency medicines were available in a secure area in the practice and all staff knew of their location. 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.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather and access to the building. The practice manager showed us the plan they were currently updating and told us they were working with other practices in the locality to identify best practice within this. They told us once finalised the plan would be held by the practice manager and GPs at their homes and linked practices so contact details were available if the building was not accessible.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety.

Good

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 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 98.3% points available for clinical indicators. This was above both the local Clinical Commissioning Group (CCG) and national 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 most of the comments made by patients who completed Care Quality Commission (CQC) comment cards. Interviews with GP 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, learning disabilities and prescribing and for providing enhanced services to local care homes. 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 two 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 anticoagulation (blood thinning) treatment in patients with atrial fibrillation (an irregular heart rhythm) to make sure treatment offered to patients was in line with national guidance. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the Quality and Outcomes Framework (QOF). The practice 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 benzodiazepines (a range of drugs normally prescribed to treat anxiety, sleeping problems and other disorders) to reduce prescribing levels in line with national guidance. This had resulted in a 9% reduction in prescribing these drugs.

Good

Are services effective?

(for example, treatment is effective)

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice was undertaking regular reviews of patients with diabetes for known risk factors and performance was in line with national averages. The practice had achieved 100% of the QOF points available in the management of long term conditions such as asthma, chronic obstructive pulmonary disease (lung disease) and dementia.

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 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 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. There were also care plans 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. 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.

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 line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP.

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.

The practice had identified a gap in health provision for patients who were over the age of 75 and housebound, but were not known to the practice through their work on the review and management of patients with long-term conditions. The practice intended to implement a register and provide an annual home visit review for these patients to ensure their needs were being met.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. 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.

The practice closed for an afternoon of Protected Learning Time (PLT) on three occasions a year to join with local practices for educational and training sessions. 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).

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.

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.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

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

We saw various multi-disciplinary meetings were held. For example, there was a monthly meeting to review all unplanned admissions of patients to hospital. This meeting was attended by the GPs, practice nurses, administrative leads and district nurses. The practice received a list of unplanned admissions and attendance at accident and emergency (A&E) to support them to monitor this area.

Safeguarding and child protection meetings were held weekly. These were attended by Health Visitors, District Nurses, Midwives, School Health Advisers, Practice Nurses and GPs. Palliative care review meetings were held monthly. This helped to share important information about patients including those who were most vulnerable and high risk.

In addition to this the practice had a proactive approach to regularly identify, review and plan how they met the needs of all identified vulnerable patients. This included those patients whose needs might not otherwise be considered through multidisciplinary meetings, such as safeguarding or palliative care, to ensure they had planned for and were meeting the needs of these patients.

We spoke with a District Nurse and a Health Visitor linked to the practice. Both commented on the good working relationship with the practice. They told us that they were able to share information and access advice and support from the GP on a daily basis. They told is this worked very well and helped with effective safeguarding processes in the area. Both were very complementary about the practice and the staff who worked there.

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 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.

The practice worked with local voluntary organisations to help improve the health and well-being of patients. For example, the practice worked with Sustrans (a cycling charity) to organise guided cycle rides for over 50s. Practice staff helped facilitate and publicise these rides. They also took part in the rides themselves.

The practice worked with other local agencies and organisations who provided care and support to patients locally. This included a local mental health step down unit, two residential homes for people with severe learning disabilities and a women's refuge service. Where people using these services did not already have a GP, the practice supported them to access services and register with them.

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. 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 people who lacked mental capacity to consent to what was proposed were made in the person's 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.

Good

Are services effective?

(for example, treatment is effective)

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. 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.

The practice had packs of information about routine procedures, which were given to the patient prior to their appointment. This gave detailed textual information to help patients come to informed consent. The doctor would then discuss the information with the patient and confirm they agreed to the procedure before proceeding. We saw a good example of this for steroid injections.

Health promotion and prevention

We found the practice was supporting people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill health.

The practice recognised the link between improved health outcomes and the addressing of social problems, such as housing or substance misuse. The practice encouraged patients to improve their own health, and had supported practice Health Champions. The practice had signed up to this national initiative which is part of the 'Altogether Better' model of community co-production. Health Champions are people who voluntarily give their time to work with the staff in their local GP Practice or surgery to find new ways to improve the services that the practice offers, and to help to meet the health needs of patients and the wider community. The practice Health Champions were also members of the practice participation group (PPG). The practice had supported health champions in their role by discussing and providing the group with information about local health inequalities. They worked with Health Champions to develop and implement things which they identified might help improve local health outcomes.

For example, the practice identified that men locally had worse health outcomes than the national average and that men were a hard to reach group. The practice had undertaken a targeted survey to explore the issue of men's health. They published this information on their website and discussed the results of this with the Patient Participation Group and the practice Health Champions.

The PPG told us the practice had involved them in identifying ways they could encourage men aged under the age of 65 who had not attended the practice within the last three years, to improve their health and well-being. As a result, the practice, with the support of the practice Health Champions, started a walking group. This was well attended by patients. Although the issue of men's health had instigated these, the group was open to all. Following their success the practice also supported guided cycle rides for over 50s and a patient choir. This helped to support patients to improve their health and reduce social isolation of older patients.

Patients participating were also offered lifestyle advice and a blood pressure check. Only a few men had taken up these opportunities, but the Health Champions told us the practice continued to look at opportunities and activities to improve health outcomes for patients locally. They told us the practice had a strong vision that the practice was integral to the community and that community involvement would help them meet the needs of their patients.

The practice understood and responded to the needs of the local community. For example, the practice had recognised substance misuse as a social and health problem locally. Staff had undertaken additional training to help them understand these issues and the practice offered substance misuse services.

The practice recognised that social issues, such as debt and homelessness impacted on health and well-being. They had supported patients by providing information for benefit claims and social housing applications. The practice offered free of charge confirmation of identity for passport applications as they recognised it may be difficult for patients to get this proof otherwise.

New patients were offered a 'new patient check'. The initial appointment was scheduled with the Healthcare Assistant, to ascertain details of their past medical histories, social factors including occupation and lifestyle, medications and

Good

Are services effective?

(for example, treatment is effective)

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

The practice's website also provided some 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. We were told this worked well to prevent 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 year old children were in line with national averages. 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 four patients during our inspection. They were all happy with the care they received. People told us they were treated with respect and were positive about the staff. They told us they would recommend the practice to family and friends. Comments left by patients on the 33 CQC comment cards we received also reflected this. Words used to describe staff included excellent, caring, helpful, non-judgemental and attentive.

We looked at data from the National GP Patient Survey, published in July 2014. This demonstrated that patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. We saw that 99.3% (compared to 92.5% nationally) of patients said they had confidence and trust in their GP and 94.9% (compared to 82.7% nationally) said their GP was good at treating them with care and concern.

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 CQC comment cards referred to the helpful nature of staff. This was reflective of the results from the National GP Survey where 95% of patients felt the reception staff were helpful, compared to a national average of 87%.

People's 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 people's privacy and confidentiality. Voices were lowered and personal information was only discussed when absolutely necessary. Phone 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 people's dignity. Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in those rooms could not be overheard.

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.

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 83.1% of respondents said the GP was good at involving them in care decisions and 88.0% 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 majority of patient feedback on the 33 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.

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 them well in this area. For example, 94.9% of those surveyed thought the GPs they saw or spoke to was good at treating them with care and concern. Similarly, 91.6 % thought nurses did.

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. The practice had in place arrangements to support families and carers experiencing 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 people's wishes at these times. The practice website gave detailed information about the practical arrangements for when a family member dies.

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. They covered patients with diverse cultural and ethnic needs and those living in deprived areas. We found 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 GP or nurses would already be aware of this and any additional support could be provided, for example, a longer appointment time.

Longer appointments were made available for patients who needed them. 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 from 2014 confirmed this. 93.6% of patients felt the doctor gave them enough time, 91.6% felt they had sufficient time with the nurse. These results were above the national averages (85.3% and 80.2% respectively).

Tackling inequity and promoting equality

The practice had considered local health inequalities and had implemented several innovative initiatives to help patients improve their own health. In particular, these focussed on the needs of patients who may have poor access to primary care. The practice had learnt from what had gone well and also from those that were less successful.

The practice had invited Skills for People to visit the practice and check on the arrangements for meeting the healthcare needs of patients with learning disabilities in May 2014. Skills for People is a user-led, voluntary organisation working in the North East for people with disabilities, and particularly learning disabilities. As a result of the visit the practice developed easy read information leaflets. This was used to accompany the invitation sent to patients with a learning disability, requesting them to attend an annual review of their health. The visit by Skills for People, highlighted areas the practice was good at, such as explaining in easy to understand ways about medicines and what their purpose was for patients with learning disabilities.

The practice had recognised the needs of different groups in the planning of its services. For example, the practice opened on a Saturday morning for booked appointments. This helped to improve access for those patients who worked full time.

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.

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.

The practice told us they had an open policy for accepting patients onto their list. They gave us examples where they had accepted patients from out of their catchment area, who had been refused services elsewhere. For example, homeless or asylum seeking patients. They gave an example of undertaking a home visit for a patient who had a history of alcohol misuse who had been refused treatment in practices near to where they lived.

Where patients failed to attend a number of appointments, for example, due to substance misuse issues, the practice told us they would never ask the patient leave the practice. Instead they asked these patients to attend at the end of surgery, to minimise the impact of missed appointments.

The practice offered a service for patients with substance misuse. The practice had recognised this as a health issue

Good

Are services responsive to people's needs?

(for example, to feedback?)

in the local area. GPs had undertaken additional training in substance and alcohol misuse to help them meet the needs of their local community. The practice provided services for drug misusers and prescribed substitute medication working alongside the local drug, alcohol and addiction service delivered by Northumberland, Tyne and Wear NHS Trust from Plummer Court in Newcastle Upon Tyne.

Access to the service

Appointments were available between 8.30am - 6.00pm weekdays and a Saturday morning surgery between 8:30am and 11:30am for patients with pre-booked appointments. Consultations were provided face-to-face at the practice, over the telephone, or by means of a home visit by the GP. This helped to ensure people had access to the right care at the right time. Patient survey results showed that 95.7% of patients were satisfied with opening hours, compared to a national average of 76.9%.

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. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Some patients commented on CQC comment cards that it could be difficult to contact the practice to make an appointment. This was reflected in the latest patient survey information, where 78.5% said it was easy to get through to someone at the GP surgery by phone (compared to a Clinical Commissioning Group average of 80.1% and a national average of 72.9%). The practice had recognised this as an area to improve and had taken action to address this.

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. There was no detailed information about how to make a complaint available on the practice website, but there was a comment and suggestions web form. This directed patients to contact the practice if they had a complaint.

Of the four patients we spoke with and the 33 CQC comment cards, none raised concerns about the practices approach to complaints.

We saw the summary of complaints that had been received in the 12 months prior to our inspection. There were four complaints in 2014-15.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 the practice had provided further training to staff in the action to take for children with rashes.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had a strong community awareness and understood that some health outcomes were best improved by working with local people to help them improve their own health.

The practice had an annual business plan in place, with key business objectives. This was discussed in a monthly business strategy meeting. The plan set out the key priorities for the practice and how they would be achieved. This information was cascaded to staff through staff meetings. It was evident in discussions we had with staff throughout the day that it was a shared vision and was fully embedded. The Health Champions we spoke with also told us about the practice vision and how important community involvement was to the practice.

We spoke with nine 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.

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 it was performing above or in line with the averages of the local Clinical Commissioning Group (CCG) and across England as a whole. 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 GPs had leads in areas such as substance misuse, long term conditions and safeguarding children and vulnerable adults. We spoke with nine 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. The business plan in place identified priorities and supported the practice with improving quality within the practice.

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.

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). Over the last year, the practice had taken part in a Health Champions initiative with which the PPG had been

Are services well-led?

Good

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

involved. The practice told us the Health Champion initiative was ending and the work would revert to the PPG. The practice intended to re-launch the PPG within the next few months.

The practice manager showed us the analysis of the last patient survey they had carried out, which was considered in conjunction with the Patient Participation Group (PPG). The results and actions agreed from these surveys were available on the practice website.

The key priority identified for the practice from the patient survey and feedback from the PPG was to consider ways of informing patients about the availability of online services.

The practice published an annual report into the work of the PPG and this was available on the practice website.

The practice published a regular newsletter 'Let's talk' to keep patients informed about the practice and provide useful information and features. This included articles on areas such as changes in staff, the initiative for patients to access to repeat prescriptions out of hours to alleviate the pressures on out of hours services and information about NHS health checks and flu vaccinations.

NHS England guidance states that from 1 December 2014, all GP practices must implement the NHS Friends and Family Test (FFT), (the FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices). We saw the practice had recently introduced the FFT, there were questionnaires available 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. Staff we spoke with told us they regularly attended staff 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 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 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 wouldn't 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 four 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 these 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.