Longrigg Medical Centre

Quality Report

Leam Lane Estate
Gateshead
Tyne and Wear
NE108PH

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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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Longrigg Medical Centre on 13 January 2015. Overall, the practice is rated as good. Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the six key population groups.

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 appropriately recorded, monitored, reviewed and addressed;
- Risks to patients were assessed and well managed;
- The practice was clean and hygienic, and good infection control arrangements were in place;
- Patients' needs were assessed and care was planned and delivered following best practice guidance;
- Patients said they were treated with compassion, dignity and respect and that they were involved in decisions about their care and treatment;
- Information about the services provided, as well as how to raise any concerns or complaints, was accessible and easy to understand;
- Patients said they found it easy to make an appointment and urgent same-day access was also available;
- The practice had good facilities and was well equipped to treat patients and meet their needs;
- There was a clear leadership structure and good governance arrangements were in place.

We saw an area of outstanding practice:

- The practice had achieved accreditation as a 'research-ready' practice. This meant the practice had had to comply with higher standards of performance in relation to, for example, how patient information is handled and patient confidentiality is protected.

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 with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The partners and practice management team took action to ensure lessons were learned from any incidents or concerns, and shared these with staff to support improvement. There was evidence of good medicines management. Safe staff recruitment practices were followed and there were enough staff to keep patients safe. Good infection control arrangements were in place and the practice was clean and hygienic.

Are services effective?

Good

The practice is rated as good for providing effective services.

Nationally reported data showed patient outcomes for effectiveness were either in line with, or better than average, when compared to other practices in the local Clinical Commissioning Group (CCG) area. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE). Staff had received training appropriate to their roles and responsibilities. Staff had access to the information and equipment they needed to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services.

Nationally reported data showed patient outcomes for caring were either in line with, or better than average, when compared to other practices in the local CCG area. Patients said they were treated well and were involved in making decisions about their care and treatment. Arrangements had been made to ensure their privacy and dignity was respected. Patients had access to information and advice on health promotion, and they received support to manage their own health and wellbeing. Staff demonstrated they understood the support patients needed to cope with their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Nationally reported data showed patient outcomes for this area were either in line with, or better than average, when compared to other practices in the local CCG area. Services had been planned so

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they met the needs of the key population groups registered with the practice. Patient feedback about the practice was generally good. The practice had taken steps to reduce emergency admissions to hospital for patients with complex healthcare conditions, and older patients had been allocated a named GP to help promote continuity of care. The practice had good facilities and was well equipped to treat patients and meet their needs.

Are services well-led?

Good

The practice is rated as good for being well-led.

The leadership and management of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision for improving the service and promoting good patient outcomes. An effective governance framework was in place. Staff were clear about their roles and understood what they were accountable for. The practice had a range of policies and procedures covering its day-to-day activities. Systems were in place to monitor and, where relevant improve, the quality of the services provided to patients.

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 patients.

Nationally reported data showed the practice had achieved good outcomes in relation to the conditions commonly associated with older people. The practice offered proactive, personalised care to meet the needs of older people. They provided a range of enhanced services including, for example, a named GP who was responsible for overseeing the care and treatment received by the practice's older patients. Clinical staff had received the training they needed to provide good outcomes for older patients.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions.

Nationally reported data showed the practice had achieved good outcomes in relation to those patients with common long-term conditions. The practice had taken steps to reduce unplanned hospital admissions by improving services for patients with complex healthcare conditions. Patients on the practice's long-term conditions registers had received healthcare reviews that reflected the severity and complexity of their needs. Person-centred care plans had been completed for each patient. Practice nurses had received the training they needed to provide good outcomes for patients with long-term conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

Nationally reported data showed the practice had achieved good outcomes in relation to child health surveillance, and contraception and maternity services. Systems were in place for identifying and monitoring children who were considered to be at risk of harm or neglect. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age patients (including those recently retired and students.)

The needs of this group of patients had been identified and steps taken to provide accessible and flexible care and treatment. The

Summary of findings

practice was proactive in offering on-line services to patients such as being able to order repeat prescriptions and book appointments on-line. Appointments were available outside normal working hours making it easier for working patients to attend the practice. Health promotion information was available in the waiting area and on the practice web site. The practice had exceeded the national target for offering their patients NHS health checks. The practice provided additional services such as smoking cessation, travel vaccinations and minor surgery.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable.

Nationally reported data showed the practice had achieved good outcomes in relation to meeting the needs of patients with learning disabilities. The practice kept a register of these patients and used this information to ensure they received an annual healthcare review and other relevant checks and tests. Staff worked with members of the multi-disciplinary team to help meet the needs of vulnerable patients. The practice sign-posted vulnerable patients to various support groups and other relevant organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children.

People experiencing poor mental health (including people with dementia)

Good

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

Nationally reported data showed the practice had achieved good outcomes in relation to meeting the needs of patients with mental health needs. The practice kept a register of these patients and used this to ensure they received relevant checks and tests. Where appropriate, care plans had been completed for patients who were on the register. Staff regularly worked with other relevant professionals to help ensure patients' needs were identified and addressed.

Summary of findings

What people who use the service say

During the inspection we spoke with two patients and reviewed 36 Care Quality Commission (CQC) comment cards completed by patients. The feedback we received indicated the majority of patients were satisfied with the care and treatment they received. Most patients told us they received a good service which met their needs.

Findings from the National GP Patient Survey published in 2015 for the practice indicated most patients had a good level of satisfaction with the care and treatment they received. For example, of the patients who responded to the survey:

- 87% said the last GP they saw, or spoke to, was good at listening to them. (This result was slightly below the national average;)
- 84% said the last GP they saw, or spoke to, was good at giving them enough time. (This result was slightly above the national average;)
- 81% said the last GP they saw, or spoke to, was good at treating them with care and concern. (This result was slightly below the national average;)
- 87% said the last GP they saw, or spoke to, was good at explaining tests and treatments. (This result was in line with the national average;)
- 100% said they had confidence and trust in the last GP they saw, or spoke to. (This result was above the national average.)

These results were based on 116 surveys that were returned from a total of 322 sent out. The response rate was 36%.

Areas for improvement

Action the service SHOULD take to improve

- Carry out a risk assessment to identify a list of emergency medicines that are not suitable for the practice to stock, or keep in their doctors' home visit bags. The practice should consider documenting the outcome of this risk assessment.

Outstanding practice

- The practice had achieved accreditation as a 'research-ready' practice. This meant the practice had had to comply with higher standards of performance in relation to, for example, how patient information is handled and patient confidentiality is protected.

Longrigg Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector**.** The team included a GP and a practice professional.

Background to Longrigg Medical Centre

Longrigg Medical Centre is a busy surburban practice providing care and treatment to 10928 patients of all ages, based on a General Medical Services (GMS) contract agreement for general practice. The practice is part of NHS Gateshead Clinical Commissioning Group (CCG) and provides care and treatment to patients living in the Gateshead area of Tyne and Wear. It serves an area that has higher levels of deprivation affecting children and people aged 65 and over, when compared to other practices in the local CCG, and also to the England average. The practice's population includes more patients aged under 18 years, and slightly less patients aged over 65 years of age, than other practices in the local CCG area.

The practice provides services from the following address, which we visited during this inspection:

Longrigg Medical Centre, Leam Lane Estate, Gateshead, Tyne and Wear, NE108PH.

The practice occupies a former private dwelling which has been extended and refurbished to meet patients' needs. The premises provide fully accessible treatment and consultation rooms on the ground floor, for patients with mobility needs. Longrigg Medical Centre provides a range of services and clinic appointments for patients with conditions such as asthma, diabetes and heart failure. The practice consists of six GPs (three male and three female), a practice manager, an assistant practice manager, three nurses, two healthcare assistants and a team of administrative and reception staff. At the time of our visit, there were also three GP Registrars (trainee doctors) on placement at the practice.

The Care Quality Commission (CQC) intelligent monitoring tool placed the practice in a band five. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience, including the Quality Outcomes Framework (QOF) and the National GP Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only takes place after a CQC inspection has been carried out. (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 e.g. diabetes and implementing preventative measures. The results are published annually.)

When the practice is closed patients can access out-of-hours care via Gateshead Community Based Care Limited, also known as GatDoc, and the NHS 111 service.

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.

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 (CQC) 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the services they provided. We carried out an announced inspection on 13 January 2015. During this we spoke with a range of staff including: three GP partners; the practice manager and assistant practice manager; two practice nurses and members of the administrative and reception team. We spoke with two patients from the practice's Patient Participation Group (PPG). We observed how staff communicated with patients who visited, or telephoned the practice, on the day of our inspection. We looked at records the practice maintained in relation to the provision of services. We also reviewed 36 Care Quality Commission (CQC) comment cards that had been completed by patients.

Good

Are services safe?

Our findings

Safe Track Record

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how they operated. Also, the information we reviewed as part of our preparation for this inspection did not identify any concerning indicators relating to safety. The Care Quality Commission (CQC) had not been notified of any safeguarding or whistle-blowing concerns regarding patients who used the practice. The local Clinical Commissioning Group (CCG) did not raise any concerns with us about how this practice operated.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. This information included, for example, significant event reports, national patient safety alerts (NPSA), and comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. The patients we spoke with raised no concerns about safety at the practice.

We saw that records were kept of significant events and incidents. The sample of records we looked at, and evidence obtained from interviews with staff, showed the practice had managed such events consistently and appropriately during the period concerned. This provided evidence of a safe track record for the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There was also evidence appropriate learning from incidents had taken place and that the findings were disseminated to relevant staff. We spoke to staff about how the practice managed the significant event/incident reporting process, and also looked at some of the records that had been kept.

We found the practice had recorded 15 significant events/incidents during the previous 12 months. For example, a report had been completed regarding an incident where the practice had issued an item of medication that was 'hospital only medication'. We saw that, following the incident, staff discussed the event during a weekly management meeting and identified what steps would be taken to prevent this from happening again. We confirmed that representatives from the various staff groups attended this meeting to enable learning to be cascaded to all practice staff. The practice had offered apologies to patients where they judged they could have done better. We were told that, where significant events or incidents had occurred, these would be discussed at a practice meeting, or another relevant meeting should this be more appropriate.

All of the staff we spoke with were aware of the system in place for raising issues and concerns. The practice also reported incidents to the local CCG, using the local safeguarding incident reporting system. Arrangements had been made which ensured national patient safety alerts were disseminated to the relevant staff. This enabled these staff to decide what action should be taken to maintain and promote patient safety. We were also told that staff used their protected learning time to discuss patient safety alerts and identify any changes that needed to be made to how the practice operated. The practice manager said they received all NPSAs via email, and that these were discussed at the weekly practice management meetings to decide what action, if any, needed to be taken. The sample of meeting minutes we looked at confirmed this.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. Safeguarding policies and procedures were in place. Information about how to report safeguarding concerns and contact the relevant agencies was easily accessible. There were designated staff in the practice who had lead roles for safeguarding children and adults. Staff we spoke with said they knew who the safeguarding leads were.

Staff had completed safeguarding training relevant to their role and responsibilities within the practice. All of the GP partners had completed child protection training to Level 3. This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns. A member of the nursing team we spoke with confirmed they had also completed both child protection and safeguarding training relevant to their role. We spoke with some of the administrative staff who were on duty at the time of our visit. All of these staff

were able to describe how they would respond to a potential safeguarding concern and they knew how to access the telephone numbers of the local safeguarding agencies.

A chaperone policy was in place and information about this was displayed in the reception area. Chaperone training had been undertaken by all staff who carried out chaperone duties. The patients we spoke with said they knew they could access a chaperone if they needed one.

Patients' records were kept on an electronic system. This system stored all relevant information about patients, including scanned copies of communications from hospitals. Children and vulnerable adults who were assessed as being at risk were identified using READ codes. These codes alerted clinicians to their potential vulnerability. (Clinicians use READ codes to record patient findings and any procedures carried out). Arrangements were in place to follow up children who failed to attend appointments to help ensure they did not miss important immunisations. Practice staff used their multi-disciplinary team (MDT) meetings to review each patient considered to be at risk and, where appropriate, to share any relevant information.

Staff were able to easily access the practice's policies and procedures. This helped to ensure that, when required, all staff could access the guidance they needed to meet patients' needs and keep them safe from harm.

Medicines Management

Arrangements were in place to check the storage of medicines requiring cold storage. Staff told us refrigerator temperatures were regularly checked to help ensure these medicines were stored correctly. We looked at the record kept of the checks that had been carried out and saw they were not carried out consistently. We shared this with the provider who advised the arrangements would be reviewed immediately.

The practice had arrangements in place to monitor the expiry dates of emergency medicines and medical gases. Each GP kept their own supply of emergency medicines. A member of the nursing team kept a master record showing what emergency medicines were kept at the practice and details of their expiry dates. We found all emergency medicines were in date and that an effective ordering and checking regime was in place. We identified that the practice only kept a limited supply of Adrenaline in individual doctors' emergency drug boxes. We discussed this with the practice who told us they thought this was sufficient, given the close proximity of the local hospital and ambulance service, but agreed to review their protocol. (Adrenaline is used to treat the symptoms of life-threatening allergic reactions in emergency situations.) No controlled medicines were kept on the premises.

A process was in place to handle medicines safety alerts. The practice manager told us alerts were forwarded to the practice pharmacist for processing. Decisions about whether any action needed to be taken were made during the weekly practice management meeting.

Patients were able to re-order repeat prescriptions in a variety of ways. This included ordering at the practice, by telephone, on-line and by post. The web site provided patients with helpful advice about ordering repeat prescriptions. Staff knew the processes they needed to follow in relation to the authorisation and review of repeat prescriptions. For example, they were clear about the steps to be taken when the authorised number of repeat prescriptions was reached. A member of the reception team was observed handling a request for a repeat prescription in a competent and helpful manner.

A system was in place which helped to ensure patients receiving prescribed medicines underwent a regular review. The practice told us patients would receive several reminders that they needed a medicines review and, if they failed to respond to these, their supply of medicines would be reduced to two weeks supply instead of the usual four weeks. Arrangements had also been made with a local hospital which helped to ensure that any medicines prescribed by hospital staff were reviewed and monitored by the practice to ensure patients' safety.

Cleanliness & Infection Control

The premises were clean and hygienic throughout. Patients told us the practice was always clean. Notices reminding patients and staff of the importance of hand washing were on display in toilets and other relevant areas. A cleaning schedule was in place and domestic staff had access to the equipment and cleaning materials they needed to keep the practice clean.

Good

Are services safe?

An infection control policy and procedures were in place and they covered a range of key areas such as, for example, obtaining specimens. These provided staff with guidance about the standards of hygiene they were expected to follow.

A comprehensive infection control risk assessment and audit had been completed in November 2014 in order to identify any shortfalls or areas of poor practice. An action plan with timescales for completion had been prepared to address the shortfalls identified.

The practice had a designated infection control lead who provided guidance and advice to colleagues when needed. Relevant staff had completed infection control training. The sample of staff training records we looked at confirmed this.

The clinical rooms we visited contained personal protective equipment such as latex gloves, and there were paper covers and privacy screens for the consultation couches. Arrangements had been made for the privacy screens to be regularly changed and cleaned.

Spillage kits were available to enable staff to deal safely with any spills of bodily fluids. Written instructions were in place informing staff how to do this. Sharps bins were available in each treatment room to enable clinicians to safely dispose of needles. The bins had been appropriately labelled, dated and initialled. The treatment rooms also contained hand washing sinks, antiseptic gel and hand towel dispensers to enable clinicians to follow good hand hygiene practice.

Arrangements had been made to ensure the safe handling of specimens and clinical waste. For example, the practice had a protocol for the management of clinical waste and a contract was in place for its safe disposal. All waste bins were visibly clean and in good working order. A legionella (a bacterium that can grow in contaminated water and can be potentially fatal) risk assessment had been carried out and documented checks of the hot water system were being undertaken.

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. The equipment was regularly inspected and serviced, including the testing of portable electrical equipment. We saw records confirming the calibration of equipment had been regularly carried out. An up-to-date fire risk assessment was in place and regular fire prevention checks had been carried out. We saw evidence that a fire drill had been carried out during the previous 12 months.

Staffing & Recruitment

The practice had a set of recruitment policies and procedures which provided clear guidance about the pre-employment checks that should be carried out on staff.

Pre-employment checks had been undertaken to help make sure that only suitable staff were employed. For example, written references and full employment histories had been obtained. Staff's NHS Smart cards contained a recent identification photograph and their identities had been verified under the NHS Employment Check Standards process. We checked the General Medical and Nursing and Midwifery Councils records and confirmed all of the clinical staff were licensed to practice. Disclosure and Barring Service (DBS) checks had been carried out for relevant staff in line with duties and responsibilities.

Systems were in place which helped to ensure there were enough staff on duty to maintain the smooth running of the practice and to meet patients' needs. Weekly rotas were completed so staff knew who was on duty and in what capacity. The practice management team was able to clearly describe what the trigger points were for staff shortages. They told us the weekly management meeting considered and reached agreements about how planned staff absences and shortfalls in staffing would be handled. We were told this system worked well and was effective. Locum GP use was low as shortfalls could usually be covered in-house by existing staff. We saw evidence which confirmed that succession planning had taken place in advance of the imminent retirement of two of the GP partners.

Monitoring Safety & Responding to Risk

The practice had systems in place to manage and monitor risks to patients and staff. For example, the practice had used a risk assessment screening tool to identify those patients at risk of an unplanned admission to hospital. Copies of Do Not Attempt Resuscitation orders and emergency care plans had been placed on an electronic system which provided emergency professionals and out-of-hours clinical staff with access to information about how best to meet patients' needs. The practice manager told us GPs would also write to the local out-of-hours

Good

Are services safe?

provider about patients' needs if they considered it necessary. The practice used a specific palliative care handover form to ensure the out-of-hours provider received good quality information about patients who were receiving palliative care.

The practice had a health and safety policy which provided staff with guidance about their role and responsibilities, and what steps they should take to keep patients safe. Practice staff monitored the safety of the building to ensure patients were not put at risk. This included carrying out regular checks of the premises to make sure there were no hazards. We checked the building and found it to be safe and hazard free. None of the patients we spoke to raised any concerns about health and safety.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing that staff had received training in cardio-pulmonary resuscitation (CPR.)

Emergency equipment was available, including access to oxygen, an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and an emergency medicines kit. The staff we spoke with knew the location of this equipment and we were able to confirm that this equipment was regularly serviced and well maintained. Emergency medicines were stored securely so that only relevant practice staff could access them. They included, for example, medicines for the treatment of a life-threatening allergic reaction. Emergency oxygen was also available. Arrangements were in place to regularly check the emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date.

The practice had a comprehensive business continuity plan for dealing with a range of potential emergencies that could impact on the day-to-day operation of the practice. Mitigating actions had been recorded to reduce and manage the risks. The practice manager confirmed the plan was due to be reviewed before the end of March 2015.

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 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. 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 maximum points (with an overall score of 99.3%) for all but one of the 20 clinical conditions covered, i.e. Diabetes Mellitus. In respect of this clinical condition, the practice had obtained 94.1% of the points available to them. However, this was above both the local Clinical Commissioning Group (CCG) and England averages. (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 e.g. diabetes and implementing preventative measures. The results are published annually.)

Clinical staff had access to a range of electronic care plan templates and assessment tools which they used to record details of the assessments they had carried out and what support patients needed. For example, the GP partners used a standardised dementia screening tool to help identify and treat patients with potential cognitive impairments.

Practice staff had the knowledge, skills and competence to enable them to respond appropriately to patients' needs. The practice manager showed us a training matrix which detailed what training staff had completed and when. We saw clinical nursing staff had access to training on, for example, smoking cessation, influenza and immunisations and carrying out an electrocardiogram (ECG.) This is equipment to record electrical activity of the heart to detect abnormal rhythms and the cause of chest pain. A practice nurse confirmed they had all of the training they currently needed to carry out their role.

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 staff and two practice nurses demonstrated the culture in the practice was that patients were referred to relevant services on the basis of need. Patients' age, sex and race was not taken into account in this decision-making.

The practice had achieved accreditation as a 'research-ready' practice. This meant the practice had had to comply with higher standards of performance in relation to, for example, how patient information is handled and patient confidentiality is protected. At the time of our inspection, the practice was participating in a study looking at barriers to the uptake of colorectal cancer screening.

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, medicines management and for providing an enhanced service to a local care home. 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.

The practice manager and GP partners monitored how well the practice performed against key clinical indicators such as those contained within the QOF. Clinical and non-clinical staff were responsible for recording information to enable judgements to be made about compliance with QOF targets.

The practice had carried out a range of clinical audits to help improve patient outcomes. A clinical audit had been carried out in 2012 to check whether patients with a

specific type of diagnosed heart failure were receiving the treatment recommended by the National Institute for Health and Care Excellence (NICE.) The original clinical audit had been repeated to check that patients with this disease continued to receive the recommended treatment. We also saw the GP completing the audit had identified in their planning that the original NICE guidance had been updated. The practice was able to show that, for patients with this type of heart failure, the percentage receiving an ECG had almost doubled. We saw nursing staff had been reminded of the importance of carrying out an annual ECG for this type of patient.

We were also provided with details of other clinical audit activity within the practice, and of the outcomes these had had for improving patient health. For example, an audit had been carried out to review the use of Warfarin with patients who had heart disease and were at high risk of a stroke. Clinical discussions had taken place with affected patients and Warfarin had been prescribed where appropriate. The practice found there had been increased take-up of Warfarin by high risk patients. Other clinical audits included a review of obese patients who were receiving a combined oral contraceptive, and a review which focussed on making sure patients with Coeliac disease were receiving the right medical treatment.

The practice was proactive in the management, monitoring and improving of outcomes for patients. They used the information collected for the QOF, and information about its performance against national screening programmes, to monitor outcomes for patients. For example: 97.2% of patients with cancer, diagnosed within the previous 15 months, had had a review recorded within three months of the practice receiving confirmation of the test results; 94.3% of patients with a diagnosis of heart failure had had this confirmed by an echocardiogram or by specialist assessment, three months before or 12 months after being entered onto the practice's disease register. We confirmed the practice had achieved all of the points available to them for delivering good clinical care to patients with a range of conditions such as epilepsy, asthma and chronic obstructive pulmonary disease (COPD). (This is the name for a collection of lung diseases including chronic bronchitis, emphysema.) The information we looked at before we carried out the inspection did not identify this practice as an outlier for any QOF (or other national) clinical targets.

Effective systems were in place which helped to ensure patients received prompt care and treatment. For example, all discharge and other advisory letters were first reviewed by the administrative team, and then forwarded to the relevant GP for action. The administrative team handled all Choose and Book requests which provided patients with an opportunity to influence what services they used and when.

Effective staffing

The staff team included medical, nursing, managerial and administrative staff. The partnership consisted of six GP partners. The GPs had completed additional training to help them deliver the care and treatment they provided. For example, one of the GPs acted as the mental health lead. We were told this person had completed training in psychotherapy. The practice maintained a copy of each GPs qualifications (including the GP Registrars') to help make sure medical staff working within the practice were appropriately qualified. The GPs we spoke with told us those GPs who were GP trainers had attended a local trainer conference which was part of their continuing professional development. This enabled the practice to provide placements for GP Registrars.

All the GPs were up –to-date with their annual continuing professional development requirements and all had either had been revalidated or had a date for their revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). The majority of other staff had received an appraisal during the previous 12 months, and arrangements had been made to provide an appraisal for one remaining member of staff.

The practice nurses we spoke with told us they were expected to perform defined duties and they were able to demonstrate they were trained to fulfil these duties. For example, they told us they had completed training in sexual health and carrying out immunisations. The sample of training records we looked at confirmed this. Both staff told us about the previous experience they had brought with them which they felt helped them to carry out their role at the practice. Our interviews with staff confirmed the practice was proactive in providing staff with access to appropriate training that was relevant to their role.

Good

Are services effective?

(for example, treatment is effective)

We looked at the practice staff rotas and identified there was always a minimum of one GP on duty when the practice was open. The practice manager told us holidays, study leave and sickness were covered in-house wherever this was possible. Although administrative and support staff had clearly defined roles, they were also able to cover tasks for their colleagues in their absence. This helped to ensure the team were able to maintain the needed levels of support services at all times. We saw evidence of succession planning in team meetings, to address the imminent departure of two of the GP partners.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. The practice received written communications from local hospitals, the out-of-hours provider and the 111 service, both electronically and by post. Staff we spoke to were clear about their responsibilities for reading and actioning any issues arising from communications with other care providers. They understood their roles and how the practice's systems worked.

The practice held regular multi-disciplinary meetings to discuss patients with complex needs, for example, those with end-of-life care needs. These meetings were attended by the GPs, practice nursing staff as well as local healthcare professionals such as health visitors and midwifes. There was an established link between the practice and a local nursing home within its catchment area, which involved a GP carrying out a weekly visit. GP staff told us this helped to ensure patients living there received more person-centred care and treatment.

The practice had participated in the development of a local project, along with other practices, to hold multi-disciplinary meetings with the aim of delivering patient centred co-ordinated care to patients over 75 years of age who have had an unplanned admission into hospital. The practice manager told us involvement in the project required the practice to build relationships with local community organisations such as AGE UK and the medical and nursing teams based at the local hospital.

Information Sharing

The practice had systems in place to provide staff with the information they needed to carry out their roles and responsibilities. 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.

The practice used several systems to communicate with other providers. For example, there was an agreed process for accessing information from the local out-of-hours provider which ensured the practice received written information about contact with any of its patients. Any information received was firstly reviewed by one of the GPs to identify if any action needed to be taken, and then scanned onto the patient's electronic medical records.

The practice shared information about patients with complex care and treatment needs, or those who had an agreed Do Not Attempt Resuscitation order in place, with out-of-hours and urgent care providers. This enabled patient data to be shared in a secure and timely manner.

Electronic systems were also in place for making referrals using 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).

Consent to care and treatment

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the patients who participated in the 2014 National GP Patient Survey, 88% said the GP they visited had been 'good' at involving them in decisions about their care. A similar high level of satisfaction was noted in relation to the care and treatment provided by nurses working at the practice in this area.

Staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in complying with it. The GP partners we spoke with demonstrated a clear understanding of consent and capacity issues. They were able to clearly explain when consent was necessary and how it would be obtained and recorded.

The practice had a consent policy which provided clinical staff with guidance about how to obtain patients' consent to care and treatment, and what to do in the event a patient lacked the capacity to make an informed decision. This policy also highlighted how patients' consent should be recorded in their medical notes, and it detailed what type of consent was required for specific interventions.

Good

Are services effective?

(for example, treatment is effective)

Health Promotion & Prevention

The practice offered all new patients a health check with a healthcare assistant. These checks covered a range of areas including past medical history and ongoing medical problems. The practice also offered NHS Health Checks to all patients aged between 40 and 75 years of age. In 2013/14, NHS Health Checks had been provided for 20.8% of the eligible patient population. Public Health England told the practice that they had exceeded the national target.

The practice was good at identifying patients who needed additional support and were proactive in offering this. For example, there was a register of all patients with dementia. Nationally reported data for 2013/14 showed that: 83.3% of patients with dementia had received a range of specified tests six months before or after being placed on the practice's register; 89.8% of patients on the dementia register had had their care reviewed in a face-to-face interview in the preceding 12 months. (Both of these scores were above the local CCG average.) The practice had a system in place to identify patients who might be at risk of developing dementia.

Nationally reported data for 2013/14 showed the practice had recorded the smoking status of 90.1% of patients aged over 15. The figures also showed the practice supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy. The practice manager told us from 01 January 2014 to 31 December 2014, 40 patients had received smoking cessation advice, and of these, 16 had stopped smoking.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice regarding levels of patient satisfaction. This included information from the 2014 National GP Patient Survey. The evidence from these sources showed the majority of patients were satisfied with how they were treated and the quality of the care and treatment they received. For example, of the patients who responded to the GP Patient Survey: 84% said the last GP they saw, or spoke to, was good at giving them enough time; 87% said the last GP they saw, or spoke to, was good at listening to them; 81% said the last GP they saw, or spoke to, was good at treating them with care and concern. All of these scores were above the local CCG average. Scores for nurses working at the practice were also higher than the local CCG average in all of the areas referred to above.

We received 36 completed CQC comment cards. The majority of feedback received from patients was positive, with only a very small number raising concerns about the care and treatment they had received. We also spoke with two patients from the Patient Participation Group (PPG) on the day of our inspection. They told us the practice offered a good service and staff were caring, polite, helpful and welcoming. They confirmed they were treated with dignity and respect, and said staff were professional, compassionate and understanding.

All consultations and treatments were carried out in the privacy of a consulting or treatment room. There were disposable curtains in these rooms to enable patients' privacy and dignity to be maintained during examinations and treatments. Consultation and treatment room doors were kept closed when the rooms were in use, so conversations could not be overheard. Information we looked at before the inspection indicated that a small proportion of respondents to the National GP Patient Survey were unhappy that conversations with the receptionists might be overheard by other patients. We spent some time in reception and, although there was a potential for patients to be overheard, there was notice informing patients they could speak to a receptionist in private if they so wished. The practice had also installed a self-check in screen so that patients attending for appointments could book-in in private. A new glass enclosure had been installed in the reception area to prevent telephone conversations being overheard.

Care planning and involvement in decisions about care and treatment

Data from the National GP Patient Survey 2014 showed patients were positive about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example: 88% of respondents said their GP involved them in decisions about their care; 87% felt the GP was good at explaining treatment and results. Both of these responses were above the local CCG average. The patients who completed CQC comment cards did not raise any concerns in this area and neither did either patient we spoke to on the day of our inspection.

Staff told us translation and interpreter services were available for patients who did not have English as a first language. Providing these types of services helps to promote patients' involvement in decisions about their care and treatment.

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 who completed CQC comment cards, raised any concerns about the support they received to cope emotionally with their care and treatment. Notices and leaflets in the waiting room sign-posted patients to a number of relevant support groups and organisations. The practice website and their patient leaflet included information about how patients could access the emotional support they needed. For example, the practice leaflet contained contact details for a local carers support group and a veteran support organisation. The practice's computer system alerted clinicians if a patient was also a carer, so this could be taken into consideration when they assessed their needs for care and treatment. Clinical staff referred patients struggling with loss and bereavement to an appropriate support group. These arrangements encouraged and supported patients to manage their own health, care and wellbeing.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of older patients and those with long-term conditions. Staff used a risk assessment tool to profile patients according to the risks associated with their conditions. This had enabled them to identify patients at risk of, for example, an unplanned admission into hospital. The practice kept registers identifying which patients had diagnosed long-term conditions, and they had written to each patient aged 75 years and over, explaining which GP would act as their named doctor. The practice had identified that the numbers of older patients being referred to the 'Improving Access to Psychological Therapies' (IAPT) programme was fewer than for other registered patients. The GPs told us the practice was taking action to identify more patients over 65 years of age who might benefit from this service. (IAPT is a programme to improve access to talking therapies in the NHS by providing more local services and psychological therapists.)

The practice nursing team were responsible for the delivery of chronic disease management. The practice offered patients with long-term conditions, such as asthma and Chronic Obstructive Pulmonary Disease (COPD) an annual check of their health and wellbeing. Where it was judged necessary these checks were carried out more often. Nursing staff told us patients were recalled for reviews during their birthday month, during which screening tests would be completed and lifestyle advice and guidance given.

The Patient Participation Group members (PPG) we spoke with said the appointment 'recall' system worked well and they felt they received good support and advice from the nursing team. Of the patients who participated in the 2014 National GP Patient survey: 92% said the last nurse they saw was good at explaining tests and treatment; 100% said they had confidence and trust in the last nurse they saw or spoke to. Both of these scores were above the local Clinical Commission Group (CCG) average.

The practice had set up a register of patients who were in need of palliative care and their IT system alerted clinical staff about which patients were receiving palliative care. This helped to ensure the practice was aware of which patients required extra support, care and treatment. Nationally reported data for 2013/14 showed that multi-disciplinary team (MDT) meetings took place regularly (at least every three months) to discuss and review the needs of each patient on this register. The achievement score for this was in line with the local CCG average, and above the England average.

The practice had identified the needs of babies, children and younger patients, and put plans in place to meet them. For example, the practice specifically provided young people with access to relevant information on a noticeboard in the entrance area. Young people had access to advice and guidance regarding sexual health, as well as access to appropriate treatment. Free Chlamydia and Gonorrhoea testing kits were available in the waiting room as was health information about these conditions. The provision of this service helped young people to test for these conditions in the comfort of their own home, and encouraged them to seek advice and help at the practice.

Nationally reported data for 2013/14 showed, for example, that: child development checks were offered at intervals that were consistent with national guidelines; antenatal care and screening were offered in line with current local guidelines. The practice offered a regular baby clinic, run by a nurse and a GP, where a full range of immunisations were provided. The Care Quality Commission (CQC) had not identified the practice as being outlier with regards to the delivery of their immunisation programme. receiving vaccination

The practice had planned their services to meet the needs of the working age population, including those patients who had recently retired. For example, the practice provided an extended hours service until 7:00pm one evening a week and was open from 7:00am two mornings a week to facilitate better access to appointments for working patients. The practice website provided patients with information about how to book appointments and order repeat prescriptions, including how to do this on-line.

Nationally reported data for 2013/14 showed that working age patients had access to healthcare opportunities to help them live healthier lives. For example, 80% of eligible women had received a cervical screening test during the last five years. Protocols for the management of cervical screening, and informing women of the results of cervical screening tests were in place. The records of patients with hypertension who were aged over 16 contained evidence

Good

Are services responsive to people's needs?

(for example, to feedback?)

they had received a brief intervention in the preceding 12 months. Data also showed the practice provided women with access to contraceptive services and advice. For example, 91.2% of women aged 54 or under, who were prescribed an oral or patch contraceptive method, had received advice about long-acting reversible methods of contraception during the previous 12 months.

The practice had identified those patients who were also carers. This was flagged on the practice's computer system to alert clinicians so it could be taken into account when assessing these patients' care and treatment needs. We saw evidence confirming the practice had referred 14 carers to the local carers association within the last 12 months. Information for patients who were also carers was easily accessible within the practice reception area.

The practice worked collaboratively with other agencies and regularly shared patient information to ensure good, timely communication of changes in care and treatment. The practice provided the out-of-hours and emergency care services with access to care plan information for patients who had palliative care or complex health needs. This enabled them to access important information about these patients when necessary and provide appropriate care.

Tackle inequity and promote equality

The practice had made arrangements which demonstrated their commitment to tackling inequity and promoting equality. For example, all GP partners and GP registrars (trainee doctors) had received training in promoting equality and diversity.

The majority of patients did not fall into any of the marginalised groups, such as homeless people and Gypsies and Travellers, that might be expected to be at risk of experiencing poor access to health care. The GPs told us the practice took whatever action they could to meet the needs of patients who fell within this population group. For example, the practice had made suitable arrangements to identify and meet the needs of patients with learning disabilities, complex health conditions, and those receiving palliative care. They had a number of veterans registered with the practice. These patients had been identified on the practice's IT system to help ensure their particular needs were identified and addressed.

Reasonable adjustments had been made which helped patients with disabilities, and patients whose first language was not English, to access the practice. The practice premises had been adapted to meet the needs of patients with disabilities. For example, the reception area and some of the consultation and treatment rooms, were located on the ground floor. There was a disabled toilet which had appropriate aids and adaptations. The doors into the practice opened automatically. The waiting area was spacious making it easier for patients in wheelchairs to manoeuvre. The practice had a small number of patients whose first language was not English. Practice staff had access to a telephone translation service and interpreters should this be required.

Access to the service

Appointments were available from 08:00am to 6:00pm two days a week. Extended hours were also provided between 07:00am and 6:00pm two days a week and between 08:00am and 7:00pm one day a week. Providing extended hours makes it easier for working age patients and families to obtain an appointment outside of normal surgery hours.

Patients were able to book appointments by telephone, by visiting the practice or on-line via the practice web site. Patients were also offered routine appointments which they could book several months in advance. The practice website confirmed that patients who felt they needed to be seen 'soon' were offered an appointment within two working days. The practice manager told us patients requesting a same-day urgent appointment would always be contacted to determine the most appropriate response to their needs, such as telephone advice, a home visit or alternative help. Patients were sent text reminders to help reduce the number of missed appointments.

The practice demonstrated they had a very responsive approach to ensuring they were able to respond to increasing and variable demands for appointments. A system was in place which included the monitoring of the daily demand for appointments. Demand for appointments, and the capacity of the practice to meet this, was discussed at the weekly management meeting. The practice had a clear view about what the trigger points were for increasing capacity. Cancellation of surgeries was rare and only happened at times of unplanned absence.

Of the patients who participated in the 2014 National GP Patient Survey: 86% said they were satisfied with the practice's opening hours; 70% of those who had a preferred GP, usually got to see or speak to that GP; 85% said they

Good

Are services responsive to people's needs?

(for example, to feedback?)

found it 'easy' to get through on the telephone to someone at the practice; 76% said they usually waited 15 minutes or less after their appointment time to be seen, and 60% said that they didn't normally have to wait too long to be seen. All of these scores were above the local CCG average. We spoke with two members of the PPG and all confirmed they were satisfied with the practice's appointment system. No concerns were raised by patients who completed Care Quality Commission (CQC) comment cards.

The practice's website and leaflet provided patients with information about how to access out-of-hours care and treatment. When the practice was closed there was an answerphone message giving the relevant telephone numbers patients should ring.

Listening and learning from concerns and complaints

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

Information was available to help patients understand the complaints process. The practice website provided patients with clear information about how to complain, and included timescales within which concerns would be addressed. The website informed patients that an apology would be offered where the practice had not got things right. Information about how to complain was also available within the practice reception area. The PPG members we spoke with said they had never had to make a complaint but would feel comfortable in doing so. A suggestions box was available in the waiting area providing patients with an opportunity to raise concerns anonymously.

The practice had received 13 complaints during the previous 12 months. We saw eight complaints had been resolved and five were still in the process of being investigated. From the information supplied by the practice, we were able to confirm they responded appropriately to concerns raised and apologised when they did not do as well as they should have done. This included meeting patients to address the concerns they raised face-to-face. Clinicians had used practice meetings to review what had happened, and what could be learnt to prevent a reoccurrence.

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. This was clearly outlined in their mission statement and charter of patients' rights. The mission statement, which was on the practice website and in its information leaflet, stated: 'Longrigg Medical Centre is committed to providing you and your family with the highest possible quality care. We have a dedicated and professional team who are here to listen and provide patient centred care to you.' The practice demonstrated its commitment to providing good outcomes for patients by, for example, providing opportunities for GP Registrars (trainee doctors) to complete their training at Longrigg Medical Centre. The practice acted as an assessment practice for GP Registrars in need of extra support to develop their skills and competencies. The practice carried out research in a variety of areas in order to promote good outcomes for patients as well as for patients in general. Staff told us they knew and understood what the practice was committed to providing and what their responsibilities were in relation to these aims.

Governance Arrangements

The practice had a range of policies and procedures in place governing its activities and the services they provided to patients. Staff were able to access these in a variety of ways. Each year the practice completed the Department of Health Information Governance Toolkit to help ensure information was handled sensitively and in a secure and confidential manner.

Nationally reported Quality Outcomes Framework (QOF) data for 2013/14 confirmed the practice participated in an external peer review with other practices in the same Clinical Commissioning Group (CCG), in order to compare data and agree areas for improvement. (Peer review enables practices to access feedback from colleagues about how well they are performing against agreed standards.) The practice had also carried out a range of clinical audits aimed at improving the quality of care and treatment provided to patients.

The practice used the QOF data to measure their performance. Nationally reported data taken from the QOF for 2013/14 showed the practice had achieved an overall score of 99.3% of the maximum points available to them, for delivering care in line with the QOF clinical indicators. This achievement was above both the local CCG and the England averages. This confirmed the practice had delivered care and treatment in line with expected national standards. QOF performance data was regularly monitored by the practice management team and feedback was provided to clinicians so that any corrective action required could be taken. This helped to ensure all staff were aware of how the practice was performing.

Leadership, openness and transparency

There was a well-established management structure and a clear allocation of responsibilities, such as clinical lead roles. We were able to talk with some of the GP partners, a member of the nursing team, as well as members of the practice management team. All of these staff demonstrated a good understanding of their areas of responsibility and took an active role in trying to ensure patients received good care and treatment. The staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued, were well supported and would feel comfortable raising concerns with the practice management team or the GP partners.

There were systems and processes in place which facilitated the collection of information to enable effective judgements to be made about the performance of the practice and where improvements needed to be made. For example, we found IT support was effective. Practice management staff used a local risk assessment tool to carry out searches of patient information enabling them to generate data about which patients required what care, and how and when this should be provided. The practice IT system provided clinicians with access to a range of referral forms and chronic disease templates. These helped to ensure patients received prompt care because the right information about their needs had been collected during consultations.

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

Regular practice and multi-disciplinary team (MDT) meetings took place where operational issues and patients' needs were discussed. We were told these meetings had

Are services well-led?

Good

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

been in place for many years and were 'well-bedded into the day-to-day work of practice staff'. We looked at a sample of meetings and found good minutes were kept. Staff used these meetings to discuss practice based issues and significant events, and to agree ways of working together to improve how the practice operated and outcomes for patients. Staff told us there was an open culture within the practice and they were happy to raise issues at team meetings.

Systems were in place to identify and manage risks. For example, the practice had a business continuity plan to help ensure the service could be maintained in the event of foreseeable emergencies. The practice manager told us that the weekly management meetings were used to discuss any concerns or risks to patients and how these would be managed.

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

The practice had made arrangements to seek and act on feedback from patients and staff. For example, patients were invited to complete a Friends and Family Survey (FFS) following a visit to the practice. The practice website included a link to the FFS. The practice had an active patient participation group (PPG). Information about how to join the group was on the practice website, and an information poster had been placed in local pharmacies and community centres. The 2014/15 PPG report identified that the current membership was not fully representative of the wider practice population. The practice had recognised this as a weakness and was actively recruiting representatives from patients with different ethnic backgrounds.

The PPG met monthly and representatives from the practice always attended to support the group. We spoke with two members of the PPG and they felt the practice welcomed their involvement and responded positively to their comments, and to any work they thought it might be useful to undertake. We saw the PPG had an agreed action plan for 2014/15. Early in 2014, with the support of the PPG, the practice carried out a survey to look at the reasons why registered patients visited the local accident and emergency (A&E) unit. We saw the practice and the PPG had evaluated the results, and agreed subsequent actions aimed at encouraging patients' use of the practice during opening hours, rather than the local A&E unit. Information about the outcome of the survey had been placed on the practice website so this could be accessed by patients and other interested parties.

The practice had gathered feedback from staff through regular staff meetings and staff appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The staff we spoke to felt valued and said they felt they were an important part of the practice team. Staff told us there was a shared sense of direction which was communicated effectively, and this ran through everything they did.

Management lead through learning & improvement

The practice provided staff with opportunities to continuously learn and develop. Practice nursing staff told us they had opportunities for continuous learning to enable them to retain their professional registration, and develop the skills and competencies required for chronic disease management. All of the staff we spoke to said their personal development was encouraged and supported.

Staff said they took part in regular 'time-out' sessions which enabled them to complete the training required for their continuing professional development. Reviews of significant events had taken place and the outcomes had been shared with staff via meetings to help ensure the practice improved outcomes for patients through continuous learning.

The practice demonstrated their strong commitment to learning by providing opportunities for GP Registrars to complete their specialist training. The practice had achieved accreditation as a training practice. This meant they had to meet higher than usual standards of performance in areas such as patient medical records and providing a safe working environment. The practice also provided undergraduate teaching in association with Newcastle Medical School.