Central Gateshead Medical Group

Quality Report

Central Gateshead Medical Group,
The Health Centre, Prince Consort Road,
Gateshead, Tyne and Wear, NE8 1NB
Tel: 01914772243
Website: www.centralgatesheadmedicalgroup.co.uk

Date of inspection visit: 27 January 2015
Date of publication: 30/04/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Central Gateshead Medical Group on 27 January 2015. Overall the practice was rated as good. They were good at providing safe, effective, caring, responsive and well-led services. They were also good for providing services for all of the population groups.

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;
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and training planned;
- 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;
- The practice had recently appointed and was in the process of training a Primary Care Navigator. This role had been implemented to direct patients to the most relevant sources of advice or support locally;
- 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 it acted on.

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

- Continue to implement identified improvements to protect patients from the risks associated with cleanliness and infection control.

Summary of findings

- Make sure there are robust processes in place to check sterile equipment, such as syringes, are within date for use.

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. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and mostly well managed.

The practice had undertaken infection control audits but had been unsuccessful in implementing planned action to address concerns. The practice planned to follow up these concerns at a full staff meeting within the next few weeks. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care excellence and used it routinely. Patients' needs were assessed and care and treatment was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

The practice had systems in place for completing clinical audit cycles to review and improve patient care. Staff had received training appropriate to their roles and any further training had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams. Discrimination was avoided when making care and treatment decisions.

The practice had recently appointed and was in the process of training a Primary Care Navigator. This role had been implemented to direct patients to the most relevant source of advice or support locally. This included referrals to support organisations, voluntary groups, charities and health and well-being services.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several areas of care. Patients were treated with compassion, dignity

Summary of findings

and respect and were involved in decisions about their care and treatment. Information to help patients understand services available was easy to understand. We also saw 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. The practice had reviewed the needs of the local population and engaged with the NHS England area team and local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

Some patients told us and commented on CQC comment cards that it could be difficult to get an appointment at times. The practice was aware of this issue and had taken action to explore the reasons for this and address them. They had identified several areas of action and were in progress of implementing these. We saw the practice had included the Patient Participation Group (PPG) in this process and had worked with them to identify and agree improvements. Urgent appointments were available on the day. The practice offered some patients email consultations to discuss ongoing treatment or test results.

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 the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this. The strategic aims set out in the practice business plan were used in the practice appraisal process to provide a strong link between the development of the practice and the development of staff.

There was a clear leadership structure and staff felt supported by management. A number of staff told us since appointed the practice manager had been instrumental in driving the strategy and culture of the practice. They said this had been positive for staff and had increased support. 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 had demonstrated quality improvements through completed audit cycles. The practice sought feedback from

Summary of findings

staff and patients, which it acted on. The practice actively involved the PPG in seeking improvements to the service. 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 older people in its population. They provided a range of enhanced services, including for example, in dementia, providing services for patients in a local care home 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. 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 this was their preference.

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 admissions were identified as a priority. Longer appointments and home visits were available when needed. Nursing and healthcare staff were in the process of being trained to provide a long-term condition review service for housebound patients. All these patients had a named clinician and a structured annual review to check that their health and medication needs were being met. For those with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package.

The practice met all minimum standards for the Quality Outcome Framework (QOF) in the management of long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD) and epilepsy. The practice had recently contracted with the local GP federation (of which it is part), Gateshead Community Based Care to deliver the recall and review appointment booking service for patients with long-term conditions. Staff told us this worked well.

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 who were at risk. For example, children and young people with a high number of A&E

Summary of findings

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.

The practice had implemented improvements to maintain the confidentiality of young people following a significant event. As a result they identified all young people reaching the age of consent to remove parental phone numbers. Practice staff were knowledgeable about consent issues for children and young people.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the services it offered to ensure these were accessible, 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 of this age group. The practice offered some patients email consultations to discuss ongoing treatment or test results.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those in drug rehabilitation services and patients with a learning disability. They carried out annual health checks for people with a learning disability. It offered longer appointments for those who required them.

The practice regularly worked with the multi-disciplinary teams in the case management of vulnerable people. They had told vulnerable people how to access various support groups and voluntary organisations. The practice had strengthened this with the appointment of a Primary Care Navigator.

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 offered an enhanced service for patients seeking help with substance misuse. This service was available for all patients locally, including those who were not registered with the practice. There were three GPs in the practice accredited to work in substance

Summary of findings

misuse services. The practice worked closely with other specialist substance misuse agencies to offer this service. The practice had audited their work in this area, which evidenced continuous improvement in this area.

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 six patients during the inspection. We also spoke with a member of the practice Patient Participation Group (PPG) by telephone following the inspection.

Patients told us staff were friendly, 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.

Some patients told us that at times it was difficult to make an appointment. This was supported by results of the latest GP Patient survey information where the number of respondents who reported they found it easy to get through to the surgery was lower than the national average at 55.9% (national average 72.9%). The number who responded they were able to get an appointment to see or speak to someone the last time they tried was also lower at 79.3%, compared to a national average of 85.7%. One CQC comment card also included a comment about lack of availability of pre-bookable appointments

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

We reviewed 18 CQC comment cards completed by patients prior to the inspection. Patients commented positively on staff being polite and helpful, taking action when needed and the practice being clean and safe. Three comment cards included concerns, but no key themes were identified. One patient commented that they had raised their concerns with a GP and these had been resolved very quickly and to their satisfaction.

The latest GP Patient Survey published in 2015 showed the majority of patients were satisfied with the services the practice offered. Most of the indicators below are above or in line with national averages. Of the patients who responded:

- 90.2% described their overall experience of this surgery as good (national average 85.7%);
- 82.7% would recommend this surgery to someone new to the area (national average 78.7%);
- 78.9% were satisfied with the surgery's opening hours (national average 76.9%);
- 99.1% said the last appointment they got was convenient (national average 91.9%).

These results were based on 123 surveys that were returned from a total of 359 sent out; a response rate of 34%.

Areas for improvement

Action the service SHOULD take to improve

- Continue to implement identified improvements to protect patients from the risks associated with cleanliness and infection control.
- Make sure there are robust processes in place to check sterile equipment, such as syringes, are within date for use.

Central Gateshead Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

A **CQC Lead Inspector.** The team included a GP and a specialist adviser with a background in practice management.

Background to Central Gateshead Medical Group

Central Gateshead Medical Group practice is located in Gateshead. The practice provides services to around 10241 patients. The practice delivers services from Central Gateshead Medical Group, The Health Centre, Prince Consort Road, Gateshead, Tyne and Wear, NE8 1NB.

It is based in a purpose built building. All patient facilities are on the ground floor. It also offers on-site parking, disabled parking, a disabled WC, wheelchair and step-free access.

The practice has six GP partners, two salaried GPs, a GP Registrar, a nurse practitioner, two practice nurses, three healthcare assistants, a practice manager and assistant 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 Monday, Tuesday and Wednesday 7:30am to 7:00pm, Thursday and Friday 7:30am to 6:00pm. The phone lines are open on Monday between 8:30am to 6:30pm and Tuesday to Friday between 8:30am to 6:00pm.

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 Gateshead Community Based Care Limited, which is also known locally as GatDoc.

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 77 years and the average female life expectancy is 81. There is a slightly higher percentage of patients reporting with a long-standing health condition (practice population 55.8% compared to a national average of 54%). There is a slightly lower percentage with health-related problems in daily life (41.1% compared to 48.8% nationally). There are a lower number reporting caring responsibilities at 16.8% 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

Detailed findings

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

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

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. This 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 27 January 2015. We spoke with six patients and 11 members of staff. We spoke with and interviewed four partner GPs, a registrar doctor, the practice manager and assistant practice manager, two members of the nursing team, a healthcare assistant and a reception team leader. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 18 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe track record

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, an immunisation was given to a child when there was no information about previous immunisation status. The learning from this incident included changing the process so the immunisation status was checked prior to the appointment, wherever possible, to reduce the risk of this occurring again.

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

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We tracked 46 incidents 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. The practice used the 'London Protocol' to support them in the investigation and analysis of clinical incidents. This protocol sets out the process of incident investigation and analysis for use by clinicians and others wishing to reflect and learn from clinical incidents.

Where incidents and events involved third parties or external organisations, these were also added to the local CCG 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, the practice had identified that a text message appointment reminder had been sent to the parent of a young person over the age of 18. They introduced a new process to identify all young people reaching the age of consent to remove parental mobile telephone numbers and ask patients to reconfirm contact details on a regular basis. 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, where they recognised events that demonstrated processes in place successfully reduced risks to patients. This helped them confirm what had gone well so they could ensure this continued.

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

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, record safeguarding concerns and contact the relevant agencies in working hours and out-of-normal hours. Contact details were easily accessible on the practice intranet. There were also safeguarding protocols displayed in the reception and administration team office areas for staff to refer to.

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

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

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. Reception staff acted as a chaperone. Receptionists had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

The practice had processes in place to ensure the safe management of medicines. However, some improvements were needed.

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, and which described the action to take in the event of a potential failure. We found that mostly staff followed this, but there was a gap in records for October 2014. Staff were unable to tell us why this lapse had occurred.

Although there were processes in place to check medicines and consumables, such as bandages and syringes, were within their expiry date and suitable for use, these were not always effective. We checked a sample of stock in the treatment room, a consultation room and two doctors' bags. All of the medicines we checked were within their expiry dates. However, there were two out-of-date syringes, with the syringes having gone out-of-date in April 2008. The practice took action to dispose of these on the day of the inspection.

Members of the nursing staff were qualified as independent prescribers. We saw evidence they received regular supervision and support in their role. As well as updates in the specific clinical areas of expertise for which they prescribed.

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

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

There were safe procedures in place to issue repeat prescriptions. The practice had in place a flow chart to support staff in managing the process for repeat prescribing in a safe way.

Good

Are services safe?

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

We saw evidence that the infection control lead had carried out infection control audits over the last two years. Similar actions were identified at each audit. For example, staff drinks had been found in the fridge used to store vaccinations at each audit. Therefore, we found the practice were unable to demonstrate sustained learning and improvement in this area. The practice planned to follow up these concerns at a full staff meeting within the next few weeks.

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. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury.

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

We saw a number of patients hand in specimens to reception staff to send away for testing. We observed this was done in a way to minimise the risk of infection. Gloves were available to staff to use in handling specimens.

The practice manager told us the fabric privacy curtains in the consultation rooms were changed and laundered every three months or more frequently if necessary. This was carried out by NHS Property Services who owned the practice building and the practice provided evidence that this was done following the inspection.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles. There were sharps disposal boxes in all the clinical areas of the practice. There were also contracts in place for the collection of both general and clinical waste.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. The defibrillator in the practice was maintained by NHS Property Services. There was no record in the practice to demonstrate that the batteries had been checked and the electrodes were out of date. This had been highlighted to the landlord two weeks previously but action to address this had yet to take place. They told us that all other equipment was tested and maintained regularly. 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. 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 it 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 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.

Good

Are services safe?

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

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

Monitoring safety and responding to risk

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

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

The practice did not have formal arrangements in place to regularly gain assurances that routine checks on the environment, fixtures, fittings and equipment provided by the landlord NHS Property Services were being carried out. The practice had sought assurances across a number of areas prior to the CQC inspection and was able to provide some information following the inspection.

The practice manager showed us evidence they had regular informal correspondence with the landlord. This included highlighting areas where shortfalls or the need for further action were identified. For example, the practice had not conducted a fire drill within the last year; this was highlighted to the landlord for action. However, the practice had not taken its own action to address this shortfall by arranging its own fire drill.

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). Although the electrodes for the defibrillator were out-of-date.

Emergency medicines were available in a secure area and all staff knew of their location. There was a laminated sheet that clearly listed the contents of the trolley and this corresponded to the medicines available. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. However, this did not provide appropriate assurances that consumables such as syringes were in date. Our checks found a number of syringes were out-of-date.

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. Copies of the plans were held by the practice manager and GPs at their homes 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 98.4% of the points available to them for providing recommended treatments for the most commonly found clinical conditions. 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 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 staff and two 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, prescribing 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.

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

The practice had a system in place for completing clinical audit cycles. The practice showed us a sample of three of the nine clinical audits undertaken within the last year. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, the practice had audited their approach to drug misuse treatment over a number of years. The audits had looked at and evidenced ongoing improvements across a number of areas. This included the number of patients in treatment, involvement with specialist substance misuse workers, and appropriate prescribing and supervision of treatment regimes. 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 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 controlled drugs to ensure they had followed national guidelines.

Good

Are services effective?

(for example, treatment is effective)

Other clinical audits completed included a review of minor surgeries and invasive procedures; an audit of patients who did not attend appointments; and, an audit of referral activity. The practice were undertaking audits related to uptake of pertussis (also known as whooping cough) vaccine in pregnancy and GP contact with child protection conferences.

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. The practice met all the minimum standards for QOF in the management of long term conditions such as asthma, chronic obstructive pulmonary disease (lung disease) and epilepsy. The practice was in the process of training health care assistants and practice nurses to enable them to provide a long-term conditions review service for housebound patients in the future.

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. Care plans were also being developed 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 practice offered an enhanced service to the local linked care home. They undertook weekly visits to the care home to meet the needs of patients living there.

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In accordance with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. There was a structured flow chart in place to support staff with decision-making in relation to issuing repeat prescriptions.

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

Effective staffing

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

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

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

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.

Good

Are services effective?

(for example, treatment is effective)

We looked at the practice staff rotas and identified there was always more than one GP on duty when the practice was open. 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.

Working with colleagues and other services

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

We saw various multi-disciplinary meetings were held. For example, there was a quarterly meeting to review all unplanned admissions of patients to hospital. This meeting was attended by the GPs, practice nurses, administrative leads and the community matron. The practice received a list of unplanned admissions and attendance at accident and emergency (A&E) to support them to monitor this area. This helped to share important information about patients including those who were most vulnerable and high risk.

Child protection and palliative care review meetings were held quarterly. The practice had identified that as district nurses and health visitors were not linked to the practice, there was limited input from them to the relevant meetings. The practice was looking at alternative approaches to sharing information.

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

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

The practice had recently appointed a Primary Care Navigator. Their role was to direct patients to the most relevant source of advice or support locally, such as support organisations, charities and health and well-being services. This staff member was currently building the knowledge base needed to fulfil this role. This service was being developed across the locality, which supported the development of a locality wide knowledge base and provided support and cover between practices.

The practice was working with the local federation to deliver efficiencies. The practice had recently contracted with the federation, Gateshead Community Based Care (CBC), to deliver the recall and review appointment booking service for patients with long-term conditions. Practice staff told us this was working well. A staff member had been seconded to support the setup of this service, and had become an expert on the practice IT system. Staff told us they had brought useful knowledge back, and this had been very beneficial to the practice as a whole.

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

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

Health promotion and prevention

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

Information on a range of topics and health promotion literature was available to patients in the waiting area 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 take action to improve and maintain it.

The practice's website also provided links to other websites and information for patients on health promotion and prevention.

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

The practice offered a full range of immunisations for children, as well as travel and flu vaccinations, in line with current national guidance. MMR vaccination rates for five year old children were 91.1% compared to an average of 91.5% in the local CCG area. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was in line with the national average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with six patients during our inspection. They were all happy with the care they received. Patients 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 18 CQC comment cards we received also reflected this. Words used to describe the approach of staff included respectful, helpful and trustworthy.

We looked at data from the National GP Patient Survey, published in January 2015. This demonstrated that patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. We saw that 93.6% (compared to 92.5% nationally) of patients said they had confidence and trust in their GP and 88.3% (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 Care Quality Commission (CQC) comment cards referred to the helpful nature of staff. This was reflective of the results from the National GP Survey where 94% of patients felt the reception staff were helpful, compared to a national average of 87%.

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

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

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

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

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, the survey showed 81.7% of respondents said the GP was good at involving them in care decisions and 82.8% 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 18 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.

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.

Good

Are services caring?

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 88.3% of those surveyed thought the GPs they saw or spoke to was good at treating them with care and concern. Similarly, 83.4 % thought nurses did.

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

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

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

Support was provided to patients during times of bereavement. Families were offered a visit from a GP at these times for support and guidance. Staff were kept aware of patients who had been bereaved so they were prepared and ready to offer emotional support. The practice also offered details of bereavement services. Staff we spoke with in the practice recognised the importance of being sensitive to patients' wishes at these times.

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 people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the national GP patient survey published in January 2015 confirmed this. 90.4% of patients felt the doctor gave them enough time and 84.7% felt they had sufficient time with the nurse. These results were above the national averages (85.3% and 80.2% respectively).

The practice had a well-established virtual Patient Participation Group (PPG). We spoke with two members of the group who said they felt the practice valued their contribution. The practice shared relevant information with the group and ensured their views were listened to and used to improve the service offered at the practice. For example, PPG members told us they were involved in the decision not to move to new premises and focus instead on the renovation of the practice premises.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, opening times had been extended to provide early morning and evening 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 was implementing the NHS Year of Care initiative. The initiative helps to improve patient involvement in their care and encourages self-management of long-term conditions

Access to the service

Appointments were available on Monday, Tuesday and Wednesday between 7:30am to 7:00pm, Thursday and Friday between 7:30am to 6:00pm. Consultations were provided face-to-face at the practice, over the telephone, or by means of a home visit by the GP. The practice also undertook a small number of consultations via email to discuss on-going treatment or test results. This helped to ensure patients had access to the right care at the right time. The National GP Patient Survey results showed that 78.9% 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Some patients told us and commented on CQC comment cards that it could be difficult to get an appointment at times. This was reflected in the latest patient survey information, where 79.3% said they were able to get an appointment or see someone the last time they tried. This compared to a national average of 85.7%. Similarly 55.9% said they found it easy to get through to someone at the surgery, compared to a national average of 72.9%. The practice had recognised this as an area to improve. They were investigating the reason for patients not attending appointments, to minimise the number of wasted appointments. They had sought the views of the patient participation group and carried out an audit to support them with this. They were also exploring other ways of increasing capacity, for example, providing more out-of-hour appointments and reviewing the arrangements for nurse appointments. They were encouraging patients to book their own appointments and request repeat prescriptions online to improve the customer experience and free up more capacity to answer calls.

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 and was available on their website. The practice also had a comments box situated in the entrance foyer to enable patients to provide feedback about the service provided.

Of the six patients we spoke with, and the feedback we received from the18 CQC comment cards completed by patients, none raised concerns about the practice's approach to complaints. One patient commented that they had raised their concerns with a GP and these had been resolved very quickly and to their satisfaction.

We looked at the summary of complaints that had been received in the 12 months prior to our inspection. We found these had been reviewed as part of the practice's formal annual review of complaints. Where mistakes had been made, it was noted the practice had apologised formally to patients and taken action to ensure they were not repeated. Complaints and lessons to be learned from them were discussed at staff meetings. Changes had been implemented where necessary. For instance, following a complaint the practice had improved their referral process to protect patient confidentiality.

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 business plan in place, with key business objectives that were reviewed annually. The plan set out the key priorities for the practice and how they would be achieved. This was made available to all staff on the practice intranet. These strategic aims were also used in the practice appraisal process to provide a strong link between the development of the practice and the development of staff. It was evident in discussions we had with staff throughout the day that it was a shared vision and was fully embedded in staff's day-to-day practice.

We spoke with 11 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.

Staff told us the practice manager had been instrumental in driving the strategy and culture of the practice. They told us this had supported improvement.

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 the local Clinical Commissioning Group (CCG) and England averages. Performance in these areas was monitored by the practice manager and GPs, supported by the administrative staff. We saw that QOF data was discussed at team meetings and action plans were produced to maintain or improve outcomes.

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

Leadership, openness and transparency

The practice had a clear leadership structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control and GP had leads in areas such as substance misuse, long-term conditions, and sexual health and family planning. We spoke with 11 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 were some areas where the practice had not delivered on the identified areas of improvement. For example, within infection control where subsequent audits had identified similar issues. They had plans in place to further reinforce the required improvements with staff.

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.

Are services well-led?

Good

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

The practice had a virtual patient participation group (PPG). The practice had worked to increase the numbers of patients within the virtual PPG from 35 members (in March 2013) to 501(in March 2014).

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

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 out-of-hours medical care and treatment.

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

NHS England guidance states that from 1 December 2014, all GP practices must implement the NHS Friends and Family Test (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 analysed feedback from recent staff appraisals to identify areas that staff were particularly proud of. This helped them identify when things had gone well.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at 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 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.