Drs Grainger, Joughin, Jones and Blaylock

Quality Report

Throckley Primary Care Centre
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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?	Outstanding

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Drs Grainger, Joughin, Jones and Blaylock on 10 December 2014. Overall the practice is rated as good.

Specifically, we found the practice to be outstanding for being well led. It was good for providing safe, effective, caring and responsive services.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Opportunities for learning from internal and external incidents were used effectively.
- The practice used innovative methods to improve patient outcomes. For example, co-ordinated services for families were arranged on Wednesday mornings. These included GP appointments for six week checks, practice nurse appointments for immunisations, midwife appointments for antenatal care and a health visitor drop in clinic.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients, staff and from the Patient Participation Group (PPG).
- 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.
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored, regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

Summary of findings

- The multidisciplinary working within the practice was highly structured and productive. They were focussed on risk and performance areas and the practice was able to demonstrate this resulted in improved outcomes for patients.
- Staff supported people to live healthier lives through a targeted approach to health promotion and prevention. Immunisation rates in 2013/14 were well above averages for the Clinical Commissioning Group (CCG).
- The practice were strong supporters of social prescribing. This encouraged patients to manage their own health, care and wellbeing.
- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found leaders had a shared purpose and strived to deliver and motivate staff to succeed.
- The leadership, governance and culture of the organisation were used to drive and improve the delivery of high quality, person-centred care.
- There was strong working ethic of collaboration and support across the staff team and a common focus on improving the quality of care and patients experiences.
- We found there were high levels of staff satisfaction. Every member of staff we spoke with was openly proud of the organisation as a place to work and spoke highly of the open and honest culture. There were consistently high levels of staff engagement.
- There was an effective governance framework to support the delivery of the practice's strategy and good quality care. The practice had a structured programme of regular governance meetings where matters such as performance, quality and risks were discussed.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up -to-date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group (CCG). The practice was using proactive methods to improve patient outcomes.

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

Are services responsive to people's needs?

Good

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

Summary of findings

Are services well-led?

Outstanding 

The practice is rated as outstanding for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients and it had an active and involved patient participation group (PPG).

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 the practice had good outcomes for conditions commonly found amongst older people.

The practice offered personalised care to meet the needs of the older people in its population. For example, all patients over the age of 75 had a named GP and patients at high risk of hospital admission had a named GP and a care plan. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. Local residential and nursing care homes had a named GP from the practice who had overall responsibility for the practice's patients who lived there. The practice participated in the 'Care Homes Programme' which offered nurse support to homes to liaise with linked GP practices and other professionals, including hospitals. The programme focused on comprehensive care planning that was reviewed six monthly.

One of the practice's Primary Health Care Team (PHCT) meetings each month was dedicated to adults and agenda items included many areas relevant to the care of older people. For example, reviews of any recent deaths and palliative care arrangements.

People with long term conditions

Good

The practice is rated as good for the population group of people with long-term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. Patients had reviews to check their health and medication needs were being met. The practice aimed to complete reviews for patients with more than one long-term condition at the same appointment; reducing the need for patients to attend on multiple occasions.

For those people with the most complex needs the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care. One of the practice's Primary Health Care Team (PHCT) meetings each month was dedicated to adults and agenda items included many areas relevant to the care of people with long-term conditions. For example, reviews of any new cancer diagnoses.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. One of the practice's Primary Health Care Team (PHCT) meetings each month was dedicated to children and young people. The health visitors and midwife attached to the practice attended this meeting. Matters discussed included births, postnatal visits, children who were looked after and children who were a cause for concern. Services for young people were also discussed at a recent Patient Participation Group (PPG) meeting.

Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, the practice had processes in place to identify and support local families in these circumstances.

Immunisation rates were high for all standard childhood immunisations. For example, MMR vaccination rates for five year old children were 98.9% and 96.6% for doses one and two respectively, compared to an average of 92.7% in the local CCG area for dose two.

Patients told us that children and young people were treated in an age appropriate way and recognised as individuals. Some of the patients we spoke with from this population group said they didn't like the way the appointments system operated. They said it felt like it made it more difficult for them to see a GP face to face if their child or children were unwell. All of the patients we spoke with did say they had been able to see a GP the same day if their need had been urgent. Appointments were available outside of school hours and the premises were suitable for children and babies.

Co-ordinated services for families were arranged on Wednesday mornings. These included GP appointments for six week checks, practice nurse appointments for immunisations, midwife appointments for antenatal care and a health visitor drop-in clinic. This helped the practice to be flexible if problems were identified at an appointment, as other members of staff were readily available for advice or support if required.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the 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 offer continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group.

Summary of findings

The practice offered extended opening hours. Appointments were available on Wednesday and Thursday mornings from 7.30am with GPs, practice nurses and healthcare assistants. Saturday morning appointments were available once a month with a GP or health care assistant. This made it easier for people of working age to get access to the service.

The appointments system operated by the practice meant patients could access a GP consultation by telephone at a time convenient to them. If they needed a face to face review, an appointment could be arranged by the GP taking into account the patient's availability.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities. Two of the practice nurses were responsible for making sure patients were contacted and invited for a review. This would normally be done by telephone, rather than by writing them a letter. All patients with learning disabilities had a care plan and were given a copy to take away with them. The practice offered longer appointments for people, if required.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. The practice's Primary Health Care Team (PHCT) meetings each month for adults and children were focused on identifying and supporting vulnerable individuals and families. The practice had sign-posted vulnerable patients to various support groups and third sector organisations.

Consulting rooms within the practice were made available to other services; for example, drug and alcohol teams and domestic violence support workers. The practice recognised that for many of its vulnerable patients, the surgery was viewed as a safe place.

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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health were contacted each year

to arrange a mental health review. These patients were allocated to the GP who knew them best. The GP was responsible for deciding the best way to arrange an appointment. This could include the GP telephoning the patient directly to invite them into the practice.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had care planning in place for patients with dementia. The practice had close working relationships with the local nursing and residential care homes and had good knowledge of individual patient's needs. A good example was a large home locally that was visited weekly by the dedicated GP.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. Information and leaflets about services were made available to patients within the practice. The practice had a strong commitment to social prescribing and a GP had a special interest in this area. For patients experiencing poor mental health, the practice was able to arrange follow up for them with an organisation called 'Moving Forward'. 'Moving Forward' offered support to adults who lived in Newcastle and experienced mental health needs.

Summary of findings

What people who use the service say

All the 14 patients we spoke with were complimentary about the services they received at the practice. They told us the staff who worked there were very helpful and friendly. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were generally happy with the appointments system, although some parents of young children we spoke with were not as satisfied.

We reviewed 23 CQC comment cards completed by patients prior to the inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided.

The latest National GP Patient Survey showed patients were satisfied with the services the practice offered. The results were mainly in line with other GP practices nationally, and in some areas better. The results were:

- The proportion of respondents who would recommend the surgery to somebody new in the area – 87% (national average 79%);
- The proportion of respondents who were able to get an appointment to see or speak to someone the last time they tried – 88% (national average 86%);
- The proportion of respondents who said the last appointment they got was convenient – 96% (national average 92%);
- The proportion of respondents who were satisfied with the surgery's opening hours – 83% (national average 77%)
- The proportion of respondents who find it easy to get through to this surgery by phone – 88% (national average 73%);
- The proportion of respondents who described their overall experience of this surgery as good – 93% (national average 86%)

These results were based on 105 surveys that were returned from a total of 284 sent out; a response rate of 37%.

Outstanding practice

- The multidisciplinary working within the practice was highly structured and productive. They were focussed on risk and performance areas and the practice was able to demonstrate this resulted in improved outcomes for patients.
- Staff supported people to live healthier lives through a targeted approach to health promotion and prevention. Immunisation rates in 2013/14 were well above averages for the Clinical Commissioning Group (CCG).
- The practice were strong supporters of social prescribing. This encouraged patients to manage their own health, care and wellbeing.
- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found leaders had a shared purpose and strived to deliver and motivate staff to succeed.
- The leadership, governance and culture of the organisation were used to drive and improve the delivery of high quality, person-centred care.
- There was strong working ethic of collaboration and support across the staff team and a common focus on improving the quality of care and patients experiences.
- We found there were high levels of staff satisfaction. Every member of staff we spoke with was openly proud of the organisation as a place to work and spoke highly of the open and honest culture. There were consistently high levels of staff engagement.
- There was an effective governance framework to support the delivery of the practice's strategy and good quality care. The practice had a structured programme of regular governance meetings where matters such as performance, quality and risks were discussed.

Drs Grainger, Joughin, Jones and Blaylock

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Drs Grainger, Joughin, Jones and Blaylock

The practice is located in Throckley in the West of Newcastle upon Tyne. The practice serves the areas of Throckley, Newburn, Lemington, West Denton, Blucher, Walbottle, Abbey Grange, Chapel House, Chapel Park and Heddon-on-the-Wall. The practice provides services from the following address and we visited here during this inspection:

Throckley Primary Care Centre, Tillmouth Park Road, Throckley, Newcastle Upon Tyne, Tyne and Wear, NE15 9PA.

The practice provides all of its services to patients at ground floor level, with the first floor offices provided for staff use only. It offers on-site parking including some disabled parking bays, a WC and step-free access. The practice provides services to around 6,600 patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

The practice has five GP partners and a salaried GP (two male GPs, four female GPs overall), two GP registrars (fully-qualified doctors who spend time working in a practice to develop their skills in general practice), three practice nurses, two healthcare assistants, a practice manager and nine administrative support staff.

The CQC intelligent monitoring placed the practice in a band six. 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 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 comes after a CQC inspection has taken place. The CQC intelligent monitoring system placed the area the practice was located in the fourth more deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The practice's age distribution profile was very similar to the England averages for both males and females.

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

Why we carried out this inspection

We inspected this service as part of our 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 at that time.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included the local Clinical Commissioning Group (CCG). This did not highlight any significant areas of risk across the five key question areas.

We carried out an announced visit on 10 December 2014. We visited the practice's surgery in Throckley in the West of Newcastle upon Tyne. We spoke with 14 patients and a range of staff from the practice. We spoke with the practice manager, five GPs, a GP registrar, two practice nurses, a health care assistant and some of the practice's administrative and support staff. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 23 CQC comment cards where patients, members of the public and other healthcare professionals had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe Track Record

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how this practice operated. Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed Care Quality Commission (CQC) comment cards reflected this.

As part of our planning we looked at a range of information available about the practice. This included information from the latest GP Patient Survey results published in July 2014 and the Quality Outcomes Framework (QOF) results for 2013/14. The latest information available to us indicated there were no areas of concern in relation to patient safety.

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety. For example, an incident had been recorded where a vaccine fridge had been turned off for more than 24 hours. On investigation, it was identified this had been a human error and immediate action was taken to dispose of the affected stock, re-schedule clinics and order new stock. The fridge had been turned off in an attempt to improve the quality of an ECG recording being taken in the room. An electrocardiogram or ECG is equipment to record electrical activity of the heart to detect abnormal rhythms and the cause of chest pain. As a result of this incident, ECGs were now carried out in rooms without fridges and we saw signs had been placed on the backs of doors alerting staff to check fridges were on before they left rooms with them in.

The practice used the local Clinical Commissioning Group (CCG) wide Safeguard Incident Reporting Management System (SIRMS) to record incidents and provide feedback on patients' experiences in secondary care in the area. We saw a report written by the local CCG in November 2014 identified the practice as the highest responder within the CCG up to and including October 2014. This was both in terms of the total number of reports made and the number of reports made per 1,000 patient list size. This showed the practice were engaged in the reporting of and learning from incidents involving their patients in other care settings and positively reflected their open culture.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw records were kept of significant events that had occurred. We looked at records of events recorded during the last 12 months. Significant events were discussed at the practice's weekly Primary Health Care Team (PHCT) meetings and a dedicated meeting occurred every three months to ensure actions had been taken after past events. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff, were aware of the system for raising significant events and said they felt encouraged to do so.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who managed and monitored them. We looked at 28 incidents recorded in the last 12 months and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, the issue of an incorrect prescription had led to the review and re-circulation of the practice's prescribing policy to all staff.

National patient safety alerts were received into the practice electronically by the practice manager, a nurse and a member of the administrative team. The alerts were reviewed and when relevant to the practice, circulated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. For example, the practice had received guidance to cover the steps primary healthcare practitioners should take in the event of a person with a known virus making first contact with the service. In response to this, a file had been created with information in for staff to refer to, and notices for patients had been put on display. Staff said alerts were discussed at PHCT meetings to ensure they were aware of any relevant to the practice and where action needed to be taken.

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

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

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, patients who had been subjected to, or were deemed to be at risk of domestic violence, were flagged on the system. A recent in-house training session had focused on these areas and had highlighted a need for clinical staff to be more informed about female genital mutilation and child sexual exploitation. As a result, the practice had updated its mandatory training programme to include these issues.

A chaperone policy was in place and a notice was displayed in the patient waiting area to inform them of their right to request one. Clinical staff and a small number of trained administrative staff carried out chaperoning duties when patients requested this service.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence audits had been carried out to assess the completeness of these records and action had been taken to address any shortcomings identified.

Medicines Management

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

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

We saw records of the actions taken in response to reviews of prescribing data. For example, during the past year the practice had employed a pharmacist on a locum basis to help the practice with prescribing issues. The practice had also completed an audit on the effective prescribing of a medicine used to treat urinary tract infections (UTI's). This had resulted in a reduction of prescribing that was potentially ineffective from 24% to just under 8%.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw prescription forms were stored in a locked cupboard in a locked room. Access to this room from the public areas of the building was further restricted by a keypad security system. These arrangements were in line with best practice guidance issues by NHS Protect. We saw records of blank prescription form serial numbers were recorded, including those prescription pads kept in the GPs bags.

Cleanliness & Infection Control

We saw the premises were clean and tidy. Cleaning services were provided by NHS Property Services. We saw there were cleaning schedules in place and cleaning records were kept. We also saw records of audits of the quality of domestic cleaning. The most recent audit in September 2014 showed a score of 98% had been achieved. 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 infection control and carry out staff training. All staff received induction training about infection control specific to their role, and thereafter annual updates were provided internally or at 'Time-Out' training sessions. We saw evidence of infection control audit activity, the most recent of which was completed in November 2014 by the infection control lead nurse, supported by a healthcare assistant. We saw that actions identified had been completed, for example, a cabinet in the practice's communications room that was found to be dirty had been cleaned.

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

Hand hygiene techniques signage was displayed throughout the practice. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

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

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment; for example, weighing scales and blood pressure monitoring equipment.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with an appropriate professional body and criminal record checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. Staffing levels were reviewed weekly by the GP who led on this area with support from the receptionist who led on appointments. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. There were arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. The practice manager said the practice rarely used locum GPs, as their own GPs were able to cover for each other. If a locum GP was required, the practice would try to use GPs who had previously spent time in the practice as part of their training. They said this helped to keep any disruption to a minimum as they would be familiar with how the practice worked.

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

Monitoring Safety & Responding to Risk

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

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to manage the risk. We saw where risks had been identified, action plans had been drawn up to reduce these risks. Some of the actions identified had already been taken and others were planned. For example, it had been identified as a risk that not all staff were aware of the location of the gas and electric supply shut-off points within the practice. Action had been taken to reduce this risk by informing staff

Good

Are services safe?

and putting this information on display on the staff noticeboard. We saw that risks were discussed at Primary Health Care Team (PHCT) meetings and within staff meetings.

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

Arrangements to deal with emergencies and major incidents

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

Emergency medicines were available in a secure area of the practice and all the staff we spoke with knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice maintained a resuscitation medicines list and this corresponded with the medicines held. A defibrillator and oxygen were accessible and records of daily checks of the defibrillator and monthly checks of the oxygen were up-to-date. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity and recovery plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The plan had been reviewed recently and the practice manager told us it would be reviewed again in February 2015 in line with the start dates of the next GP Registrars to join the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure and loss of access to the building. The practice manager and one of the GP partners led on this area.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could describe the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE). We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs and these were reviewed when appropriate. For example, we were told that patients with long-term conditions were invited into the practice to have their medication reviewed for effectiveness.

The practice had a 'clinical management framework', within which GPs and nurses led in specialist clinical areas such as cancer, mental health and elderly care. GP leads had overall responsibility for ensuring the disease or condition was managed effectively in line with best practice. Nursing leads were jointly responsible with GPs for ensuring the day-to-day management of a disease or condition was in line with practice protocols and guidance. Clinical staff we spoke with said they would not hesitate to ask for or provide colleagues with advice and support. Staff had access to the necessary equipment and were skilled in its use; for example, blood pressure monitoring equipment and an electrocardiogram (ECG) machine.

The practice held weekly Primary Health Care Team (PHCT) meetings. One of these meetings each month focused on Quality and Outcomes Framework (QOF) performance and other patient outcome data. 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; for example diabetes; and for implementing preventative measures. Regular review of this information helped to ensure patients received effective care and outcomes.

The practice worked with the local Clinical Commissioning Group (CCG) as part of their practice engagement plan. This resulted in the practice agreeing a number of targets to be achieved. They had also started to use a web based tool in conjunction with the CCG. This allowed them to view and monitor secondary care activity for their patients and to focus on specific patient groups, such as older people and those with long term conditions.

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

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

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

The practice had a rolling programme of clinical audit. We looked at two examples of clinical audits that had been undertaken in the last year. Both of the audits included repeat audit cycles, where the practice was able to demonstrate the changes resulting since the initial audits had been carried out. For example, the practice had completed an audit on the effective prescribing of a medicine used to treat urinary tract infections (UTI's). This had resulted in a reduction of prescribing that was potentially ineffective from 24% to just under 8%. Another audit had resulted in a reduction in the number of patients prescribed medicines that placed them at high risk of gastro-intestinal ulcers.

The team was making use of clinical audit tools and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon 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.

The practice was proactive in the management, monitoring and improving of outcomes for patients. For example, they used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. The practice had achieved 98.7% of the points available in 2013/14, which included all of the points available for epilepsy, heart failure and asthma. We saw asthma was a clinical domain within QOF

Good

Are services effective?

(for example, treatment is effective)

where the practice had made significant improvements since 2012/13. The GP who led on this area said this was as a result of improvements the practice had made to its recall system for these patients.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also participated in local benchmarking. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes comparable or favourable to other practices in the area. For example, the practice compared favourably to others in the area on the prescribing of antibiotics and hypnotics and not so favourably on the prescribing of laxatives. The practice manager said the practice was looking to make improvements in this area through their participation in the 'Newcastle Care Homes Programme'. This programme focused on comprehensive care planning for care home residents with linked GP practices.

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

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were in training to be qualified as GPs had access to a senior GP throughout the day for support. Feedback from the trainee we spoke with was positive.

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

We saw the practice had an induction programme to be used when staff joined the practice. This covered an introduction to colleagues, familiarisation with the building, health and safety and the staff handbook. New employees were also asked to complete an induction process evaluation form to provide feedback on how effective the process had been.

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

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage patients with complex health conditions. Blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service, were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers promptly and efficiently. The practice had significantly reviewed their mail processing system in 2012. The review involved staff representatives from the whole practice team. The review resulted in more efficient processes and significantly faster turnaround times for any actions that needed to be communicated to patients. This work was recognised at a national level, and the practice was awarded 'Practice Administration Team of the Year' at the National General Practice Awards 2012 ceremony. Staff said these improvements had been maintained. All the staff we spoke with understood their roles and felt the system in place worked well.

GPs told us they worked well together as a team. An example of this was the regular checking of each other's test results, including blood test results. Daily clinical meetings for GPs were also held and were used to discuss cases, allocate home visits and to review any urgent correspondence.

Good

Are services effective?

(for example, treatment is effective)

The practice held multidisciplinary PHCT team meetings four times a month to discuss the needs of high risk patients, for example, those with end of life care needs. The focus of these meetings ran on a four-weekly cycle and focused on adults, children and young people, practice performance (e.g. Quality and Outcomes Framework (QOF) performance) and clinical guidelines. These meetings were attended by district nurses, social workers and palliative care nurses, and decisions about care planning were documented. For example, any new diagnoses of cancer were reviewed at adult meetings in order to review previous contacts with these patients to see if any lessons could be learned. All of the practice's GPs attended these meetings and felt this system worked well. They remarked on the usefulness of the meetings as a means of sharing important information.

The practice also had developed links with Macmillan nurses and palliative care teams, the local pharmacy, a psychiatry consultant and other members of local mental health teams.

Information Sharing

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

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. Training had been completed, both internally via e-learning and externally at the quarterly 'Time Out' training days run by the local Clinical Commissioning Group (CCG). An internal training session for all staff focused on capacity and consent was also planned for June 2015. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. They also demonstrated an understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

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

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

Health Promotion & Prevention

The practice offered all new patients a consultation. Clinicians completed the 'new patient assessment' which involved explaining the service to the patient, reviewing their notes and medical history, and the recording of basic information about the patient. For example, confirming any medicines they were currently taking. New patients were asked to make an appointment with the healthcare assistant for a health check and with the doctor if they were on regular medicines. The patient's needs were assessed and where appropriate, they were placed into the relevant monitoring service. For example, children would be placed within the immunisation programme at the appropriate point.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the Clinical Commissioning Group (CCG). For example, MMR vaccination rates for five year old children were 98.9% and 96.6% for doses one and two respectively, compared to an average of 92.7% in the local CCG area for dose two. We looked at live data which showed how the practice was performing with its flu vaccination programme. The data showed the practice was achieving the highest percentage

Good

Are services effective?

(for example, treatment is effective)

of coverage of any practice in Newcastle for its target patient group. The number of patients vaccinated had already nearly reached the number achieved in the previous years' campaign. The practice had held an open access flu day clinic on a Saturday when over 1,000 patients had attended for their flu vaccinations.

We found patients with long-term conditions were recalled to check on their health and review their medicines for effectiveness. The practice's electronic system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. We were told this worked well to prevent any patient groups from being overlooked. All patients with a long-term condition were offered an annual 'birthday check'. The practice had offered flexible, integrated chronic disease management for more than 5 years. A review of this system was completed in 2013 which revealed that take up of the service could be improved.

This led to a review process which was presented to the practice's patient participation group (PPG) in June 2014. Following approval, the new system was introduced in October 2014. The system ensured that all patients with a long-term condition were offered an appointment with an appropriate member of staff. All patients had a comprehensive annual review with a GP. A further audit and review of the new system was planned for 2015. Processes were also in place to ensure the regular screening of patients was completed, for example, cervical screening.

There was a range of information on display within the practice reception area. This included a number of health promotion and prevention leaflets, for example, on smoking cessation and alcohol consumption. The practice's website included links to a wide range of patient information leaflets, including for coughs and colds, cholesterol and weight management.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

All of the 14 patients we spoke with said they were treated with respect and dignity by the practice staff at all times. Comments left by patients on Care Quality Commission (CQC) comment cards reflected this. Of the 23 CQC comment cards completed, 18 patients made direct reference to the caring manner of the practice staff. Words used to describe the approach of staff included 'professional', 'understanding', 'considerate', 'dedicated', 'friendly', 'polite', 'caring' and 'respectful'. None of the CQC comment cards completed raised any concerns in this area.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate and caring, while remaining respectful and professional. This was clearly appreciated by the patients who attended the practice.

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

Patients' privacy, dignity and right to confidentiality were maintained. For example, the practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination. 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.

Staff were aware of the need to keep records secure. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation. Staff had completed information governance training and refreshed this every 12 months.

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 87% of practice respondents said the GP was good at involving them in care decisions and 92% felt the GP was good at explaining treatment and results. Both these results were better than the local Clinical Commissioning Group (CCG) area averages of 82% and 88%. They were also better than the national averages of 75% and 82% respectively.

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 informed decisions about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and supported these views.

Staff told us that translation services were available for patients who did not have English as a first language. This service was used infrequently by patients due to the small numbers of patients involved.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice and rated it well in this area. The CQC comment cards we received were also consistent with this feedback. For example, patients commented the GPs and staff knew them well and were caring, reassuring and supportive. Patients also commented they felt staff regularly exceeded their expectations. For example, when supporting patients and helping them to cope with long term health problems.

Notices in the patient waiting room signposted patients to a number of support groups and organisations. The practice website included information to support its patients. For example, on local mental health support services that were available for patients to access.

Support was provided to patients during times of need, such as in the event of bereavement. Telephone calls were

Good

Are services caring?

made to bereaved relatives (if appropriate) at these times to offer support and guidance. Staff we spoke with in the practice recognised the importance of being sensitive to patients' wishes at these times.

The practice routinely contacted other patient groups at times when they may be more in need of support. This included contacting all new mothers to see if they needed a post-natal visit. The practice also contacted all new patients with a new serious diagnosis or if they felt patients needed follow-up after a stay in hospital.

The practice were strong supporters of 'social prescribing' and one of the GP partners had a strong interest in this area. Social prescribing is about linking people up to activities in the community that they might benefit from and connecting them to non-medical sources of support. For example, the practice regularly referred patients for support from agencies such as Age UK, Moving Forward (who provide mental health support) and for Health Trainer support. This encouraged and supported patients to manage their own health, care and wellbeing and to maximise their independence.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. For example, the practice used a traffic light system for its palliative care patients. This helped to profile patients by allocating a risk score dependent on the progression of their illness.

The practice engaged regularly with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. One of the GPs was a clinical director for the local CCG and another GP was the acting clinical director for children and young people.

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. There had been very little turnover of staff in recent years which enabled good continuity of care. For example, patients could access appointments face-to-face in the practice, receive a telephone consultation with a GP or be visited at home. Longer appointments were available for people who needed them. The appointments process is covered in more detail under the heading 'Access to the service'.

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

The practice had an active patient participation group (PPG) and met with them on a quarterly basis. An action plan had been agreed with them for 2014/15, with actions allocated to named individuals. Some actions had already been completed, with others still in progress. For example, a new 'patient information area' had already been set up in the waiting room and work was continuing to increase the size and diversity of the PPG. Patient feedback was also routinely reviewed at group meetings, including any actions taken by the practice in response.

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 appointments on two mornings each week. A Saturday morning surgery was also run once a month between the hours of 9:00am and 12:00pm. This helped to improve access for those patients who worked full time. The practice also had access to telephone translation services if required, for those patients whose first language was not English.

The premises and services had been adapted to meet the needs of people with disabilities. The main entrance and internal door had been automated to improve access and all of the treatment and consulting rooms could be accessed by those with mobility difficulties. The patient toilet could be accessed by patients with disabilities and baby changing facilities were also provided. Dedicated car parking was provided for patients with disabilities in the practice car park close to the entrance. An induction loop system was in place for patients who experienced hearing difficulties.

The practice supported staff to attend equality and diversity training as part of the 'Time Out' training sessions run by the local CCG. Staff we spoke with confirmed that they had completed the training and that equality and diversity was regularly discussed at staff meetings.

Access to the service

Most of the patients we spoke with and those who filled out CQC comment cards said they were satisfied with the appointment systems operated by the practice. Some of the patients we spoke with, mainly parents with young children, said they didn't like the way it operated. They said it felt like it made it more difficult for them to see a GP face to face if their child or children were unwell. We mentioned this to the practice manager and GPs, who said this feedback would be included as part of the on-going review of the appointments system. All of the patients we spoke with did say they had been able to see a GP the same day if their need had been urgent.

In November 2012 the practice changed its appointment system and we were told this was for a number of reasons.

Good

Are services responsive to people's needs?

(for example, to feedback?)

This included to help patients to see the GP they preferred at a time convenient to them, to help the practice make best use of clinicians' time and to provide better continuity of care for patients. The practice also felt they needed to respond to the increasing demand for appointments from patients with an acute illness.

We were told that if a patient now wanted an appointment, they would be asked to contact the surgery and be booked into a GP telephone consultation slot. This was not a triage call-back, but an actual consultation with a GP the same day at a time agreed with the patient. If after the telephone consultation, the GP felt the patient needed a face-to-face appointment, this would be arranged. At this point, the GP was given the scope to decide how long this appointment would be. Longer face-to-face appointments could be made for patients who needed them. We were told if the patients' health issue had been dealt with on the telephone, a face-to-face appointment would not be needed. The practice manager and GPs we spoke with said they felt the new system had resulted in saving patients' time, made more appointments available and allowed the practice to prioritise urgent patients.

The practice had informed all of its patients about the new system and reviewed patient feedback on an on-going basis. This include through regular meetings held with the practice's patient participation group (PPG). Minutes of these meetings showed that patient access and the appointments system was discussed regularly. An audit of the system was completed in March 2014 and alterations to improve the system were introduced as a result. Further audit work was planned for 2015. The practice were finalists in the national 'GP of the Year' awards 2014 in the 'Practice of the Year' and 'Innovators of the Year' categories. This was in recognition of the work done in attempting to improve access for their patients.

Appointments were available from 7.30am on two mornings per week and a Saturday morning surgery was held once a month. The practice's extended opening hours were particularly useful to patients with work commitments. This was confirmed by patients we spoke with who worked during the week.

Information was available to patients about appointments on the practice website. This included how to arrange appointments and home visits.

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

The practice was situated at ground level and all services for patients were provided from there. The practice had wide corridors and automated doors. This made movement around the practice easier and helped to maintain patients' independence.

We saw the waiting area was 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 and included baby changing facilities.

Listening and learning from concerns & complaints

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

We saw the practice had received six formal complaints during 2014 and these had been investigated in line with their complaints procedure. Where mistakes had been made, it was noted the practice had apologised formally to patients and taken action to ensure they were not repeated. Complaints and lessons to be learned from them were discussed at staff meetings.

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. We saw the practice had a 'suggestion box' in place on the reception desk for patients to use.

None of the 14 patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice before. In addition, none of the 23 CQC comment cards completed by patients indicated they had felt the need to complain.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found leaders had a shared purpose and strived to deliver and motivate staff to succeed. The practice's statement of purpose said its aims and objectives were "to provide patients with the highest standard of personal health care and to seek continuous improvement in the health of the practice population." The practice aimed to achieve this by "maintaining a professional and contented practice staff who were responsive to patient's needs." The practice also aimed to provide "the best possible training to medical students working within the practice." It was evident in discussions we had with staff throughout the day that these aims and objectives were fully embedded.

There was strong working ethic of collaboration and support across the staff team and a common focus on improving the quality of care and patients experiences. We spoke with a range of staff and without exception 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.

The practice manager showed us they had a 'Practice Business Plan 2015' which set out the provider's priorities for the coming year. The document made reference to objectives relating to communication, staffing, health and safety and research and development. It also stated the clinical priorities of the practice for the coming year. These included cancer care, child health, long-term conditions and access to the service. The document was due to be presented to the GP partners meeting in January 2015, where tasks would be allocated to GP leads in the relevant service areas.

Governance Arrangements

The practice had 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. These included for the recruitment of staff, age discrimination and induction information.

Staff were clear about their roles and understood what they were accountable for. The practice's clinical management and governance frameworks clearly identified areas where GPs and nurses had lead responsibilities. This clarity of accountabilities was backed up by the descriptions given to us by staff we spoke with throughout the inspection.

We saw there was an effective governance framework to support the delivery of the practice's strategy and good quality care. The practice held regular governance meetings where matters such as performance, quality and risks were discussed. The practice held multidisciplinary Primary Health Care Team (PHCT) team meetings four times a month to discuss the needs of high risk patients, for example, those with end of life care needs. The focus of these meetings ran on a four-weekly cycle and focused on adults, children and young people, practice performance (e.g. Quality and Outcomes Framework (QOF) performance) and guidelines. These meetings were attended by district nurses, social workers and palliative care nurses. All of the practice's GPs attended these meetings and felt this system worked well. They remarked on the usefulness of the meetings as a means of sharing important information.

The practice used the QOF as one of a number of ways they measured their performance. The QOF data for this practice showed it was performing above the averages of the local Clinical Commissioning Group (CCG) and across England as a whole. Performance in these areas was monitored by the practice manager and GPs, supported by the administrative staff. We saw that QOF data was discussed at team meetings and plans were produced to maintain or improve outcomes. For example, the practice had reviewed its QOF performance for 2012/13 within the 'asthma' clinical domain. Performance in this area had been below the local and national averages at that time. In response, the practice had improved it recall arrangements for its patients with asthma. This resulted in the practice achieving all of the QOF points available within this clinical domain in 2013/14 and patients with asthma received more effective care.

The practice also regularly measured its own performance in comparison to other GP practices in the area, for example, on effective prescribing and referral rates to secondary care services. This allowed the practice to highlight areas they performed well in, as well as giving them the ability to target areas where performance could

Are services well-led?

Outstanding ☆

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

be improved. For example, the practice compared favourably to others in the area on the prescribing of antibiotics and hypnotics and not so favourably on the prescribing of laxatives.

The GPs we spoke with told us peer review within the practice was strong. For example, GPs reviewed each other's patients' blood test results on a regular basis.

The team was making use of clinical audit tools and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Without exception, staff spoke positively about the culture in the practice around audit and quality improvement. The practice had a well-developed and long-standing rolling programme of clinical audits. The results of these audits and re-audits demonstrated outcomes for patients had improved and risks to their long-term health had been reduced.

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 a GP partner was the lead for teaching and safeguarding. We spoke with a range of staff and they were all clear about their own roles and responsibilities. Each of the GP partners had a number of lead responsibilities and this was not dependant on the length of time they had been a partner. For example, the most recent GP partner had a similar number of lead responsibilities as the longest serving GP partner. These included for governance, the nursing team, appraisals and training.

We found there were high levels of staff satisfaction. Every member of staff we spoke with was openly proud of the organisation as a place to work and spoke highly of the open and honest culture. There were consistently high levels of staff engagement. 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 concerns and suggestions for improvement.

We found the practice leadership proactively drove continuous improvement and staff were accountable for delivering this. There was a clear and proactive approach to seeking out and embedding new ways of providing care and treatment. Examples included work completed on access to the service and recall arrangements for specific patient groups.

GPs we spoke with said staff performance was managed with an open approach based upon appraisals, performance plans and regular reviews. All of the staff we spoke with said they enjoyed working as part of the team and were open to constructive challenge.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. The practice manager told us staff had access to all of the practice's policies online. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions on a daily basis. Staff we spoke with told us they regularly attended staff meetings, including within their own work areas and wider practice meetings. They said these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and 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 staff we spoke with, including the practice manager and GPs told us forward planning was discussed regularly among all staff. The practice had held a number of 'away day' events for GPs and staff and these had been used to involve staff in the planning and delivery of services, as well as for team building and shaping the culture of the practice. Staff said they felt listened to and their opinions were valued and contributed to shaping and improving the service.

The practice had an active patient participation group (PPG). The PPG contained representatives from various population groups and was actively trying to increase representation from the younger population. The PPG met

Are services well-led?

Outstanding ☆

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

every quarter and representatives from the practice always attended to support the group. We spoke with some members of the PPG and they felt the practice supported them fully with their work and took on board and reacted to any concerns they raised. For example, the group had used the practice's annual 'flu day' to promote their work and to try to increase its membership. We saw the PPG had an agreed action plan for 2014/15. Some actions had already been completed, with others still in progress. For example, a new 'patient information area' had already been set up in the waiting room and work was continuing to increase the size and diversity of the PPG. Patient feedback was also routinely reviewed at group meetings, including any actions taken by the practice in response.

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

Management lead through learning & improvement

The practice was a GP training practice and we spoke with a GP registrar (trainee GP) who had recently joined the practice. They told us they felt fully involved in the work of the practice and well supported by the GP who supported them directly and by the other GPs and clinical staff at the practice.

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

The practice had completed reviews of significant events and other incidents and shared these with staff via meetings. Staff meeting minutes showed these events were discussed, with actions taken to reduce the risk of them happening again. Staff we spoke with consistently referred to the open and honest culture within the practice and the leadership's desire to learn and improve outcomes for patients.

The practice was proactive with regards to improving the quality of services it provided. For example, co-ordinated services for families were arranged on Wednesday mornings. These included GP appointments for six week checks, practice nurse appointments for immunisations, midwife appointments for antenatal care and a health visitor drop-in clinic. This helped the practice to be flexible if problems were identified at an appointment, as other members of staff were readily available for advice or support if required.

The practice manager met regularly with other practice managers in the area and shared learning and experiences from these meetings with colleagues. GPs met with colleagues at locality and CCG meetings. They attended learning events and shared information from these with the other GPs in the practice. The practice had a clinical governance framework which revolved around education, discussion and implementation. Clinicians regularly fed back to their colleagues after attending educational meetings and organised 'Time Out' training events. The practice had participated in monthly educational meetings with three other local GP practices for many years. Nursing staff we spoke with said they attended a monthly CCG wide practice nurse forum which provided them with further education and support.

Information and learning was shared verbally between staff and the practice also used their intranet system to store and share information. For example, GPs would write up summaries of continuing professional development (CPD) training completed and would circulate this among their peers.