The Whickham Practice

Quality Report

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Date of inspection visit: 19 January 2015
Date of publication: 16/04/2015

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

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	10
Areas for improvement	10
Outstanding practice	10

Detailed findings from this inspection

Our inspection team	11
Background to The Whickham Practice	11
Why we carried out this inspection	11
How we carried out this inspection	11
Detailed findings	13

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of The Whickham Medical Practice on 19 January 2015.

Overall, we rated the practice as good. Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was outstanding for providing services for older people.

We found some areas of outstanding practice, although there were some areas where the practice should make improvements. Our key findings were as follows:

- Feedback from patients was positive; they told us staff treated them with respect and kindness;
- Patients generally reported good access to the practice, with urgent appointments available the same day, although some felt it took too long to see a doctor of their choice;
- Patients we spoke with told us they felt they had sufficient time during their appointment. However, results of the national GP patient survey from 2015 suggested this was not always the case. 81% of patients thought the doctors and 77% thought nurses gave them enough time. These results were below the national averages (86% and 81% respectively).
- Patients' needs were assessed and care was planned and delivered following best practice guidance;
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed;
- There was a clear leadership structure and staff felt supported by the management team. The practice actively sought feedback from patients;
- The practice was clean and hygienic, and good infection control arrangements were in place;
- A recent audit had been carried out on cancer referrals and diagnoses across the area. The results showed the practice had performed well, and had the highest rate of cancer referrals and very high screening rates. The Clinical Commissioning Group (CCG) had suggested other practices could learn from this.

We saw several areas of outstanding practice including:

Summary of findings

- The practice had signed up to the Health Champions initiative, a project supported by NHS England and the Big Lottery Fund. A number of patients volunteered and had been trained to be Practice Health Champions (Practice Health Champions are people who voluntarily give their time to work with the staff in their local GP Practice or surgery to find new ways to improve the services that the practice offers, and to help to meet the health needs of patients and the wider community).
- There were a high number of elderly patients registered at the practice (14% of patients were over 75, compared to a national average of 9.6%); staff were aware that many of these people lived alone and may have felt isolated. Staff were proactively seeking new ways to support these patients and a new service was planned for the coming months. 'Chatty champions' were volunteers who would arrange to speak to patients each week to give them support and someone to talk to.
- Care plans had been prepared for 308 older patients, to help prevent avoidable hospital admissions. Data showed there was a decrease in the number of unplanned hospital admissions and during the Christmas period there were no unplanned admissions for this group of patients.

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

The provider should:

- Take steps to review the risk assessment for legionella and implement any necessary actions.
- Clarify arrangements for the servicing and maintenance of the defibrillator.

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?

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. There were enough staff to keep people safe; staff recruitment was well managed. The practice premises were sub-leased from NHS Property Services; arrangements to manage some elements of the building, for instance legionella and defibrillator safety checks were unclear.

Are services effective?

The practice is rated as good for providing effective services. Care and treatment was being delivered in line with current published best practice. Patients' needs were being met and referrals to other services were made in a timely manner. A recent audit across the Gateshead area showed the practice was performing well on cancer referrals and diagnosis rates. The practice regularly undertook clinical audit, although some of this work had been delayed as a result of problems when a new computer system was installed. Staff had received training appropriate to their roles and arrangements had been made to support clinicians with their continuing professional development. The practice worked with other healthcare professionals to share information.

Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Patient's privacy and confidentiality was respected. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services. Services had been planned so they met the needs of the key population groups receiving services from the practice. Patient feedback about the practice was generally good. The practice management team had identified that there were concerns regarding access to appointments. This was confirmed when we spoke with patients. Steps had been taken to review and update the appointments system to improve access. The practice had good

Summary of findings

facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints procedure, with evidence demonstrating the practice made every effort to address any concerns raised with them.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision which was shared by all staff. There was an effective governance framework in place, which focused on the delivery of high quality care. We found there was a clear leadership structure and a high level of constructive staff engagement. The practice proactively sought feedback from patients and had a very active patient participation group (PPG). A number of patients had been trained to be Practice Health Champions (Practice Health Champions are people who voluntarily give their time to work with the staff in their local GP Practice or surgery to find new ways to improve the services that the practice offers, and to help to meet the health needs of patients and the wider community).

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

The practice is rated as outstanding for the care of older people.

Outstanding

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. The practice had written to patients over the age of 75 years to inform them who their named GP was. The practice was responsive to the needs of older people, including offering home visits.

There were a high number of elderly patients registered at the practice (14% of patients were over 75, compared to a national average of 9.6%); staff were aware that many of these people lived alone and may have felt isolated. Staff were proactively seeking new ways to support these patients. Plans were in place to introduce a 'Chatty Champions' service, whereby volunteers would regularly phone elderly patients who lived alone and may be isolated, to provide company and support.

Care plans had been prepared for 308 older patients, to help prevent avoidable hospital admissions. Data showed there was a decrease in the number of unplanned hospital admissions and during the Christmas period there were no unplanned admissions for this group of patients.

People with long term conditions

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

Good

The practice had well established clinics and efficient recall systems for caring for patients with long-term conditions. Arrangements were in place to ensure care was tailored to individual needs and circumstances. Lead GPs had been identified for each of the long-term conditions. Diabetic patients were managed within the practice, with very few being referred to hospital. This was more convenient for the patients.

The practice had received a national award in 2013 from the Stroke Association for the care provided to patients who had a stroke.

We spoke with GPs and nurses who told us care reviews for patients with long term conditions took place at six monthly or yearly intervals. These appointments included a review of the effectiveness of their medicines, as well as patients' general health and wellbeing. The practice ensured timely follow up of patients with long term

conditions by adding them to the practice registers. Patients were then recalled as appropriate, in line with agreed recall intervals. Monthly audits of patient attendance at recall appointments were carried out. Nationally reported data taken from the Quality Outcomes Framework (QOF) for 2013/14 showed the practice had achieved maximum points (with an overall score of 95.2%) for the majority of the 20 clinical conditions covered. However, the practice had achieved only 75.6% of the points available for the hypertension (high blood pressure) clinical condition.

Families, children and young people

Good

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

We saw the practice had processes in place for the regular assessment of children's development. This included the early identification of problems and the timely follow up of these. Systems were in place for identifying and following-up children who were considered to be at-risk of harm or neglect. For example, the needs of all at-risk children were regularly reviewed at practice multidisciplinary meetings involving child care professionals such as school nurses and health visitors.

The practice advertised services and activities available locally to families. Lifestyle advice for pregnant women about healthy living, including smoking cessation and alcohol consumption was given by the GPs and midwives. Two of the nurses were trained in family planning and the practice routinely offered contraceptive implant and coil fittings.

Appointments were available outside of school hours and reception staff had been trained to take note of any urgent problems and notify the doctor, for instance, an unwell child or parental concern. The premises were suitable for children and babies. Arrangements had been made for new babies to receive the immunisations they needed. Immunisation rates were high for all standard childhood immunisations.

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 which reflected the needs for this age group. All of the nurses were trained in cervical cytology.

Patients could order repeat prescriptions and book appointments on-line. Extended hours appointments were available until 7:30pm three evenings a week (with GPs and nurses). We saw health promotion material was made easily accessible through the practice's website. This included signposting and links to other websites including those dedicated to weight loss, sexual health and smoking cessation. The practice provided additional services such as smoking cessation advice clinics, travel vaccinations and minor surgery.

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.

Systems were in place in place to identify patients, families and children who were at risk or vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. These patients were offered regular reviews. A recent audit highlighted the DNA (did not attend) rate was high for learning disability health checks. The practice had subsequently introduced new arrangements where the reception staff would phone the patient to remind them of their appointment.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Three of the GPS had been trained to treat patients for substance abuse. These GPs held joint clinics with the specialist substance misuse team. 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 care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. The practice worked closely with multi-disciplinary

Summary of findings

teams in the case management of people experiencing poor mental health including those with dementia. The practice had care plans in place for patients with dementia. Some staff had received specific training and were recognised as 'Dementia Friends'.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. Well established relationships had been established with local organisations such as MIND and Talking Therapies. Information and leaflets about services were made available to patients within the practice.

Summary of findings

What people who use the service say

We spoke with 13 patients during our inspection. We spoke with people from different age groups, who had varying levels of contact and had been registered with the practice for different lengths of time.

They told us the staff who worked there were very helpful and polite. 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 generally reported good access to the practice and continuity of care. The majority of patients we spoke with commented they were able to get an urgent appointment at short notice.

We reviewed 24 CQC comment cards which had been completed by patients prior to our inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided.

The latest GP Patient Survey completed in 2015 showed the large majority of patients were satisfied with the services the practice offered, although there were some areas for improvement. The results were:

- The proportion of patients who would recommend their GP surgery – 80% (national average 78%);
- GP Patient Survey score for opening hours – 75% (national average 76%);
- Percentage of patients who said the GP treated them with care and concern – 84% (national average 82%);
- Percentage of patients rating their experience of making an appointment as good or very good – 65% (national average 73%);
- Percentage of patients rating their practice as good or very good – 87% (national average 86%).

Areas for improvement

Action the service SHOULD take to improve

Take steps to review the risk assessment for legionella and implement any necessary actions. We were told a risk assessment had been carried out by the building lease holders (NHS property Services). Practice staff had not been provided with a copy of the assessment and it was not available to review during the inspection. It was therefore not clear whether any actions were necessary following the risk assessment.

Clarify arrangements for the servicing and maintenance of the defibrillator. The defibrillator was owned by the building lease holder. No regular checks were carried out by practice staff on the defibrillator to ensure it was working and ready for use; however, we saw records confirming the equipment had been serviced in the week prior to our inspection.

Outstanding practice

The practice had signed up to the Health Champions initiative, a project supported by NHS England and the Big Lottery Fund. A number of patients volunteered and had been trained to be Practice Health Champions (Practice Health Champions are people who voluntarily give their time to work with the staff in their local GP Practice or surgery to find new ways to improve the services that the practice offers, and to help to meet the health needs of patients and the wider community).

There was a high number of elderly patients registered at the practice (14% of patients were over 75, compared to a national average of 9.6%); staff were aware that many of these people lived alone and may have felt isolated. A new service was planned for the coming months. 'Chatty champions' were volunteers who would arrange to speak to patients each week to give them support and someone to talk to.

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The Whickham Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team also included the following specialist advisors; a GP, a nurse and a practice manager.

Background to The Whickham Practice

The Whickham Practice is located in the town centre of Whickham, Gateshead, Tyne and Wear.

The practice provides services to around 16,400 patients from one location; Rectory Lane, Whickham, Newcastle upon Tyne, NE16 4PD. We visited this address as part of the inspection.

The practice is located in a converted former hospital. It is a Grade 2 listed, two storey building; patient facilities are situated on both floors.

The practice has seven GP partners, four salaried GPs, five practice nurses, two healthcare assistants, three phlebotomists, a practice manager, and 21 staff who carry out reception and administrative duties.

Surgery opening times at the practice are between 8:00am and 6:00pm Monday to Friday, with extended hours on Tuesday, Wednesday and Thursday evening until 7:30pm.

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 CQC intelligent monitoring placed the practice in band 6. 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.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

Detailed findings

- 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 19 January 2015. We spoke with 13 patients and 22 members of staff from the practice. We spoke with and interviewed six GPs, the practice manager, five members of the nursing team and 10 staff carrying out reception and administrative duties. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 24 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
The practice had a good track record for maintaining patient safety.

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how the 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 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 General Practice High Level Indicators (GPHLI) tool, the General Practice Outcome Standards (GPOS) and the Quality Outcomes Framework (QOF). 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.

We saw that records were kept of significant events and incidents. We reviewed a sample of the reports completed by practice staff during the previous 12 months, and the minutes of meetings where these were discussed. The records looked at showed the practice had managed such events consistently and appropriately during the period concerned and this provided evidence of a safe track record for the practice.

Learning and improvement from safety incidents
The practice was open and transparent when there were near misses or when things went wrong. There was a comprehensive system in place for reporting, recording and monitoring significant events, incidents and accidents. One of the GPs had overall responsibility for significant events, supported by a member of staff from the administration team.

We saw records were kept of significant events that had occurred during the past year, and these were made available to us. The practice manager told us all events were recorded and reviewed, to enable trends to be identified. We saw details of each event, steps taken, specific action required and learning outcomes and action points were noted.

Significant events were discussed at dedicated monthly and quarterly meetings. 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 issues to be considered at the meetings and felt encouraged to do so.

We saw there had been a significant event in relation to informing a patient about an abnormal blood test result. We saw evidence that a thorough investigation had taken place. This had identified some key learning points, which had been shared with the relevant staff. The event had been discussed within the practice and guidelines were revised to prevent this from happening in the future. The changes were implemented and the practice told us they would be reviewed at a later date to confirm they remained effective.

We discussed the process for dealing with safety alerts with the assistant practice manager. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. They told us alerts came into the practice from a number of sources. They were reviewed by the assistant practice manager, and forwarded to the relevant GP lead. Any information or new guidelines were then disseminated to relevant members of staff. The assistant practice manager was able to give examples of recent alerts and how these had been responded to. A record had been kept to indicate when alerts had been reviewed. We were told where safety alerts affected the day-to-day running of the practice; all staff would be advised via an email or in a practice meeting.

Reliable safety systems and processes including safeguarding
The practice had systems in place to manage and review risks to vulnerable children, young people and adults. Safeguarding policies and procedures were in place. These provided staff with information about safeguarding

Are services safe?

legislation and how to identify, report and deal with suspected abuse. Information about how to report safeguarding concerns and contact the relevant agencies was easily accessible.

There was an identified member of staff with a clear role to oversee safeguarding within the practice. Staff we spoke with said they knew which of the GP partners was the safeguarding lead. The GP was responsible for ensuring staff were aware of any safeguarding cases or concerns.

There was a system on the practice's electronic records to highlight vulnerable patients. Children and vulnerable adults who were assessed as being at risk were identified using READ codes. These codes alerted clinicians to their potential vulnerability (clinicians use READ codes to record patient findings and any procedures carried out).

The clinicians discussed ongoing and new safeguarding issues at their monthly meeting, and also held regular meetings with health visitors. The staff we spoke with had a good knowledge and understanding of the safeguarding procedures and what action should be taken if abuse was witnessed or suspected.

We saw records which confirmed all relevant staff had attended training on safeguarding children and adults. All of the GPs had completed child protection training to Level 3. This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns. Nurses at the practice had completed Level 2 which is more relevant to the work they carry out whilst all other staff attended Level 1 training sessions. This was confirmed by the staff we spoke with.

The practice had a chaperone policy. We saw posters on display in the waiting room to inform patients of their right to request a chaperone. Staff told us that a practice nurse or a member of the administration team undertook this role. Staff had received appropriate training and were clear about the requirements of the role.

A whistleblowing policy was in place. Staff we spoke with were all able to explain how, and to who, they would report any such concerns. They were all confident that concerns would be acted upon.

Medicines management

There were clear systems in place to manage medicines.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for checking medicines to make sure they were kept at the required temperatures.

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. Medicines to be used in emergencies were available. We saw records which showed they were regularly checked by one of the practice nurses to ensure they were within their expiry date.

Each of the GPs had a 'doctor's bag' containing medicines for use during home visits. Systems were in place to ensure these medicines were in date. The GPs were each responsible for the contents of their own bag; the assistant practice manager also held records and sent reminders to the GPs to check the expiry dates. We looked at the medicines in one of the bags; we found they were all in date.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. For example, how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

Patients were able to order repeat prescriptions using a variety of ways. This included visiting the practice, or ordering by telephone, on-line and by post. The practice website provided patients with helpful advice about ordering repeat prescriptions. All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw records of blank prescription form serial numbers were made on receipt into the practice and when the forms were issued to GPs.

Cleanliness and infection control

We looked around the practice and saw it was clean, tidy and well maintained. Patients we spoke with told us they were happy with the cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this.

The practice had established an infection control committee. One of the GPs and a practice nurses were the nominated infection control leads. We saw there was an up to date infection control policy and detailed guidance for staff about specific issues. For example, hand hygiene and use of protective clothing. All of the staff we spoke with

about infection control said they knew how to access the practice's infection control policies. Infection control training was provided for all staff annually, although not all staff had attended a training course during the past year.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. The treatment rooms had flooring that was impermeable, and easy to clean. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. The privacy curtains in the consultation rooms were cleaned (or changed if they were the disposable type) every six months or more frequent if necessary. We saw the curtains were clearly labelled to show when they were due to be cleaned or replaced.

The practice employed an external agency to clean the premises. We looked at records and saw the domestic staff completed cleaning schedules, on a daily, weekly, monthly and annual basis. One of the practice nurses carried out regular infection control audits. We saw records confirming audits had been carried out. Some minor issues had been identified, such as some antibacterial wipes were missing from two clinical rooms. There were no formal action plans in place following these audits. However, records of a follow-up audit showed the issues had been addressed.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We looked at some of the practice's clinical waste and sharps bins located in the consultation rooms. All of the clinical waste bins we saw had the appropriately coloured bin liners in place and all of the sharps bins we saw had been signed and dated as required.

Staff were protected against the risk of health related infections during their work. We asked the reception staff about the procedures for accepting specimens of urine from patients. They showed us there was a box for patients to put their own specimens in. The nursing staff then wore PPE when emptying the box and transferring the specimens. We confirmed with the practice manager that all clinical staff had up to date hepatitis B vaccinations. We saw there were spillage kits (these are specialist kits to clear any spillages of blood or other bodily fluid) located throughout the building.

The practice was unable to demonstrate that regular checks of the water system for legionella (a type of bacteria found in the environment which can contaminate water systems in buildings) were carried out. We were told a risk assessment had been carried out by the building owners. Practice staff had not been provided with a copy of the assessment and it was not available to review during the inspection. It was therefore not clear whether any actions were necessary following the risk assessment.

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.

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. The defibrillator was owned by NHS Property Services (NHSPS). The assistant practice manager told us they had made several attempts to obtain a policy on the maintenance of the defibrillator from the NHSPS but had not received any written guidance. No regular checks were carried out by practice staff on the defibrillator; however, we saw records confirming the equipment had been serviced in the week prior to our inspection.

Staffing and recruitment

We saw the practice had an up to date recruitment policy in place that outlined the process for appointing staff. These included processes to follow before and after a member of staff was appointed. We looked at a sample of personnel files. We found the appropriate recruitment checks had been completed. For instance, written references had been obtained from previous employers, and employment history information had been provided.

The practice manager and all staff that were in contact with patients had been subject to Disclosure and Barring Service (DBS) checks, in line with the practice recruitment policy. All of the GPs had undergone DBS checks as part of

their application to be included on the National Medical Performers' List. All performers are required to register for the online DBS update service which enables NHS England to can carry out status checks on their certificate.

Monthly meetings were held for line managers to review staffing levels to plan and monitor the number of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff we spoke with were flexible in the tasks they carried out. This demonstrated they were able to respond to areas in the practice that were particularly busy. For example, by helping colleagues working on the front reception desk receiving patients or by answering the telephones. Staff told us there was always enough staff on duty to maintain the smooth running of the practice and ensure patients were kept safe.

As part of the practice manager's personal development, they were about to undertake some work on the demographics of the local population with Public Health England. They planned to use the information to ensure the practice was aware of any changes to the area which may impact on capacity levels.

We asked the practice manager how they assured themselves that GPs and nurses employed by the practice continued to be registered to practice with the relevant professional bodies (For GPs this is the General Medical Council (GMC) and for nurses this is the Nursing and Midwifery Council). They told us they regularly checked the registration status for the GPs and nurses. We saw records which confirmed these checks had been carried out.

Monitoring safety and responding to risk

Feedback from patients we spoke with and those who completed CQC comment cards indicated they would always be seen by a clinician on the day if their need was urgent.

The practice had developed clear lines of accountability for all aspects of patient care and treatment. The GPs and nurses had lead roles for areas such as safeguarding and infection control. Each clinical lead had systems for monitoring their areas of responsibility, such as routine checks to ensure staff were using the latest guidance and protocols.

The practice had systems in place to manage and monitor health and safety. Staff told us the fire alarms and emergency lights were tested on a weekly basis. We saw the last fire evacuation practice was held in 2013. The practice manager said a training update session on evacuation procedures had taken place in 2014 and an evacuation practice was planned for 2015. We saw records confirming these arrangements.

The practice manager showed us a number of risk assessments which had been developed and undertaken; including a fire and a health and safety risk assessment. Risk assessments of this type helped to ensure the practice was aware of any potential risks to patients, staff and visitors and plan mitigating action to reduce the probability of harm. Plans were in place to nominate some members of staff to be health and safety 'champions' to further strengthen these arrangements.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage emergencies. We saw records showing the majority of staff had received training in basic life support. Some of the reception staff had not yet been trained. The practice manager told us training sessions had been arranged for these staff.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. The practice manager and one of the GP partners led on this area. The plans had recently been put into action following a power failure. 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.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. GPs demonstrated an up-to-date knowledge of clinical guidelines for caring for patients. There was a strong emphasis on keeping up-to-date with clinical guidelines, including guidance published by professional and expert bodies. The practice undertook regular reviews of their referrals to ensure current guidance was being followed.

All clinicians we interviewed were able to describe and demonstrate how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. New guidelines and the implications for the practice's performance and patients were discussed at monthly clinical meetings.

We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, the practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. We spoke with staff about how the practice helped people with long term conditions manage their health. They told us that there were regular clinics where patients were booked in for recall appointments. This ensured patients had routine tests, such as blood or spirometry (lung function) checks to monitor their condition.

Nationally reported data taken from the Quality Outcomes Framework (QOF) for 2013/14 showed the practice had achieved maximum points (with an overall score of 95.2%) for the majority of the 20 clinical conditions covered. (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 such as diabetes and implementing preventative measures. The results are published annually.)

The practice had achieved only 75.6% of the points available for the hypertension (high blood pressure) clinical condition. This was below both the local Clinical Commissioning Group (CCG) and England averages; 90.9% and 88.4% respectively. The GP partners felt this was due to the introduction of a new computer system during the year and said they were confident the performance during the current year would show an improvement.

Care plans had been prepared for 308 older patients, to help prevent avoidable hospital admissions. Data showed there was a decrease in the number of unplanned hospital admissions and during the Christmas period there were no unplanned admissions for this group of patients.

We were told patient safety alerts and guidelines from NICE were discussed at relevant team meetings to enable shared learning. We saw minutes of practice meetings where new guidelines were shared with staff, the implications for the practice's performance were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure each patient received support to achieve the best health outcome for them.

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 filled in CQC comment cards.

Interviews with six GPs and two practice nurses demonstrated that the culture within the practice was to refer patients onto other services on the basis of their assessed needs, and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles, which led to improvements in clinical care. We saw a number of clinical audits had recently been carried out. The results and any necessary actions were discussed at the clinical team meetings.

We looked at three clinical audits carried out over the past twelve months. Two were mid-cycle and re-audits were in progress at the time of inspection. An audit of children with asthma taking a particular type of medicine had been completed. An initial audit was carried out in September 2013. This demonstrated that six patients required a clinical review of their medicines. Measures were put into place to

contact patients and the audit was repeated the following year. The second cycle of the audit carried out in March 2014 demonstrated that all children with asthma were prescribed appropriate medicines.

The practice carried out several other regular audits. For example, each nurse who carried out cervical smear tests audited their results each month. When this policy was introduced it was found that some samples had not been sent to the laboratory. The process for sending samples to the laboratory was amended and staff received guidance on this. Further audits showed staff had followed the guidance and all samples had been sent to be analysed.

A recent audit had been carried out on cancer referrals and diagnoses across the CCG area. The results showed the practice had performed well, and had the highest rate of cancer referrals and very high screening rates. The CCG suggested other practices could learn from this.

The practice used an analysis tool, Reporting Analysis and Intelligence Delivering Results (RAIDR) to look at trends and compare performance with other practices. We reviewed a range of data available to us prior to the inspection relating to health outcomes for patients. These demonstrated that performance was in line with other practices in England in most areas.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also 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 practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of these patients and their families.

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. Once a month the practice closed during the afternoon for protected learning time (Time In, Time Out sessions). Some of the time during these afternoons was dedicated to training.

The continuing development of staff skills and competence was recognised as integral to ensuring high quality care. Role specific training was provided. The practice nurses had been trained to administer vaccines and had attended updates on cervical screening. Clinical staff had attended a training course on anaphylaxis to increase their skills and knowledge in that area. The practice provided staff with equality and diversity training. Staff were proactively supported to acquire new skills and share best practice. For example, one of the administrative team members was being supported to undertake a qualification in Management. Three of the GPS had been trained to treat patients for substance abuse. These GPs held joint clinics with the specialist substance misuse team. Staff told us they had sufficient access to training and were able to request further training where relevant to their roles.

All GPs were up to date with their yearly continuing professional development requirements and all either have 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 by NHS England can the GP continue to practice and remain on the performers list with NHS England).

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.

The practice had a comprehensive approach to the induction of new staff. We saw all new staff, from GPs to receptionists were provided with an induction pack and received a formal induction to the practice. This was monitored by the practice manager and provided new staff with opportunities to learn about the practice and their own specific role. Staff were encouraged to take the time reflect on what they had learned and regular reviews took place throughout the induction period.

The patients we spoke with were complimentary about the staff. Staff we spoke with and observed were knowledgeable about the role they undertook.

Working with colleagues and other services

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

We saw various multi-disciplinary meetings were held. For example, a monthly palliative care meeting was held, which involved practice staff and the district and Macmillan

nurses. The practice safeguarding lead had good relationships with social services, health visitors and school nurse services. Staff commented they worked well with the local CCG and felt supported. The practice had recently taken part in a CCG wide review of cancer services.

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-hour's provider and the ambulance service.

Information sharing

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. A new system had been installed in April 2014. The practice manager told us there were problems with the configuration of the system at first and they felt staff had not received sufficient support or training from the supplier. All staff had subsequently been fully trained on the system, and told us they were more confident using it since then. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used electronic systems to communicate with other providers. For example, making referrals to hospital services using the Choose and Book system (the Choose and Book system enables patients to choose which hospital they will be seen in and allows them to book their own outpatient appointments). Staff reported this system was easy to use. GPs told us they printed out details for patients during the consultation, rather than assign the task to an administrator. This meant the patient received information about the appointment quicker.

Regular meetings were held throughout the practice. These included all staff meetings, clinical meetings and multi-disciplinary team meetings. Information about risks and significant events were shared openly at meetings. Patient specific issues were also discussed to enable continuity of care.

Correspondence from other services such as blood results and letters from the local hospital including discharge summaries, was received both electronically and by post. Staff we spoke with were clear about their responsibilities for reading and taking action to address any issues arising from communications from other care providers. They understood their roles and how the practice's systems worked.

Consent to care and treatment

Before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. There was a practice policy on consent, this provided guidance for staff on when to document consent.

Staff were all able to give examples of how they obtained verbal or implied consent. We saw where necessary, written consent had been obtained, for example, for minor surgery procedures or contraceptive implants.

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.

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. Some staff had recently received specific training on consent and the MCA. Decisions about or on behalf of patients who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the MCA. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment.

Health promotion and prevention

The practice proactively identified people who needed ongoing support. This included carers, those receiving end of life care and those at risk of developing a long term condition. For example, there was a register of all patients who had been diagnosed with chronic obstructive pulmonary disease (COPD). Nationally reported data form 2013/14 showed that 92% of eligible patients on the register had a face to face review of their care in the preceding 12 months. This was slightly above the local average (91%) and national averages (90%).

Patients with long term conditions were reviewed each year, or more frequently as necessary. Arrangements were in place to contact patients who did not attend to ensure they received a review.

Good

Are services effective?

(for example, treatment is effective)

New patients were offered a ‘new patient check’, with a nurse, 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 to take action to improve and maintain it. Staff told us about some of the services offered to patients. These included ‘exercise on prescription’ and access to a local health and wellbeing service.

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 93.9% 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 higher than the overall average for other practices nationally.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with 13 patients during our inspection. They were all happy with the care they received. People told us they were treated with respect and were very positive about the staff. Comments left by patients on the 24 CQC comment cards we received also reflected this. Words used to describe the approach of staff included caring, friendly, sympathetic, attentive and helpful.

We looked at data from the National GP Patient Survey, published in January 2015. This demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the practice was above national and local average scores on whether patients would recommend the practice (80% compared to 78% nationally). We saw that 93% of patients said they had confidence and trust in their GP and 84% said their GP was good at treating them with care and concern. These scores were in line with the national averages.

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

We saw the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. Staff spoke quietly so their conversations could not be overhead. Staff were aware of how to protect patients' confidential information. There was a room available if patients wanted to speak to the receptionist privately.

Some of the reception staff told us about a system they had developed to support patients' privacy. They were aware that some patients who arrived at the desk to book an appointment did not want to necessarily disclose the nature of their illness or complaint. A chart had been produced which listed many symptoms; the patient could then point to the relevant one which enabled staff to book an appropriate appointment. Patients we spoke with told us they appreciated this system and felt it worked well.

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. Information regarding patient confidentiality was contained within the practice information leaflet.

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

Patients told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given. We reviewed the 24 completed CQC comment cards, patients felt they were involved in their care and treatment. One person commented that the doctors always checked they understood the details. Several people told us the staff discussed and explained any treatment options.

The results of the National GP Patient Survey from January 2015 showed patients generally felt the GPs and nurses involved them in decisions about their care and listened to them. Most of the scores for doctors and nurses were in line with the national and local averages:

- 88% said the last GP they saw or spoke to was good at listening to them (national average 88%)
- 78% said the last nurse they saw or spoke to was good at listening to them (national average 79%)
- 76% said the last GP they saw or spoke to was good at involving them in decisions about their care (national average 74%).

We saw that access to interpreting services was available to patients, should they require it. Staff we spoke with said the practice did not have many patients whose first language was not English. They said when a patient requested the use of an interpreter, a telephone service was available. There was also the facility to request translation of documents should it be necessary to provide written information for patients.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our visit told us staff responded compassionately when they needed help and provided support when required. The CQC comment cards we received were also consistent with this feedback. For example, patients commented that staff were caring and took time to help and support them.

We saw there was a variety of patient information on display throughout the practice. This included information on youth services, mental health, flu vaccines, support groups and a range of information regarding common health conditions.

The practice routinely asked patients if they had caring responsibilities. The practice had recently set up a carer's register to help them identify and make sure they were receiving the professional support they needed. Clinical staff referred patients struggling with loss and bereavement to support groups who provided these types of services.

Support was provided to patients during times of bereavement. Staff told us that if families had suffered bereavement, this was followed up by the practice, with either a visit or telephone call depending upon the circumstances.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to the needs of the local population. Patients we spoke with and those who filled out CQC comment cards all said they felt the practice was meeting their needs. For example, patients could access appointments face-to-face in the practice, receive a telephone call back from a clinician or be visited at home.

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.

Patients we spoke with told us they felt they had sufficient time during their appointment. However, results of the national GP patient survey from 2015 suggested this was not always the case. 81% of patients thought the doctors and 77% thought nurses gave them enough time. These results were below the national averages (86% and 81% respectively).

The practice engaged regularly with the Clinical Commissioning Group (CCG) and other practices across Gateshead to discuss local needs and service improvements that needed to be prioritised. GPs told us they had a close working relationship with the CCG and took part in many initiatives. This included involvement in a recent exercise (Have Your Say) to gather patient views to help improve services. The results were being collated at the time of our inspection; GPs told us the results would be analysed and shared with the practice team to identify areas for improvement.

The practice worked collaboratively with other agencies, regularly updating shared information to ensure good, timely communication of changes in care and treatment. 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 had established a Patient Participation Group (PPG) to help them to engage with a cross section of the practice population and obtain patient views. A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice.

We spoke with two members of the PPG; they explained their role and how the group worked with the practice. The representatives told us the PPG had a good working relationship with the practice, and felt that the GPs explained any changes in the health economy to them and listened to any concerns they had. They gave us examples of improvements that had been made following discussions between the PPG and the practice. This included amending the telephone system to help patients to get through quicker and expanding the website to include more information for patients.

Tackling inequity and promoting equality

The practice had recognised the needs of the different groups in the planning of its services. For example, opening times had been extended to provide additional appointments three evenings each week. This helped to improve access for those patients who worked full time. The computer system used by the practice alerted GPs if patients were at risk of harm, or if a patient was also a carer. Where patients were identified as carers we saw that information was provided to ensure they understood the various avenues of support available to them should they need it.

Staff at the practice recognised that patients had different needs and wherever possible were flexible to ensure their needs were met. There was a system in place to alert staff to any patients who might be vulnerable or who had special needs, such as patients with poor mental health or a learning disability. Registers were maintained, which identified which patients fell into these groups. The practice used this information to ensure patients received regular healthcare reviews and access to other relevant checks and tests. Some patients had been identified as always needing longer appointments and the system in place ensured that staff were alerted to this need.

The practice was aware of the needs of older people, for example, those with dementia. Some staff had been trained as 'Dementia Friends'. This is an initiative from the Alzheimer's Society and Public Health England to help people to understand more about dementia and how to

Good

Are services responsive to people's needs?

(for example, to feedback?)

help people with the condition. Good links with local care homes were evident. Two of the GP partners shared weekly visits and told us they had good communication with these patients, their families and the nursing staff.

There was a high number of elderly patients registered at the practice (14% of patients were over 75, compared to a national average of 9.6%); staff were aware that many of these people lived alone and may have felt isolated. A new service was planned for the coming months. 'Chatty champions' were volunteers who would arrange to speak to patients each week to give them support and someone to talk to.

Free parking was available directly outside the building. However, many patients commented that parking was difficult as the car park was often full. This was also evident on the day of our inspection. The practice team were aware of the concerns about the parking arrangements. They suggested the location of the building; in the town centre, meant it was used by the public, as well as patients.

The doors providing access to the practice had recently been automated to improve access. We saw the consulting rooms were large with easy access for all patients. There was also a toilet that was accessible to disabled patients and baby changing facilities for use. We saw that a lift was available for patients to access the upper floors of the practice building should the need arise. An hearing loop system was in place for patients who experienced difficulties with their hearing.

Only a small minority of patients did not speak English as their first language. Staff told us that usually the patient was accompanied by a family member or friend who would translate for them. There were arrangements in place to access telephone interpretation services for urgent appointments or book an interpreter to accompany patients where appointments were booked in advance.

The practice accepted any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met. Some staff had undertaken equality and diversity training in 2014, other staff were due to receive this training during the current year. Staff we spoke with confirmed this.

Access to the service

The practice was open between 8:00am and 6:00pm Monday and Friday. Evening appointments were available on Tuesdays, Wednesdays and Thursdays until 7:30pm.

Patients were able to book appointments either by calling into the practice, on the telephone or using the on-line system. Face to face and telephone consultations were available to suit individual needs and preferences. Home visits were also made available every day.

The practice manager told us if a patient wanted an urgent appointment then they could have one the same day. Reception staff had been trained to take note of any urgent problems and notify the doctor, for instance, an unwell child or parental concern. This was confirmed when we observed reception staff taking calls from patients; patients were offered appointments on the same day.

The practice management team were aware that there were concerns from patients about access to appointments. About half of patients we spoke with, and those who filled out CQC comment cards, said they felt they had to wait too long to get an appointment with a GP of their choice. The most recent National GP Patient Survey (2015) showed 86% of respondents were able to get an appointment or speak to someone when necessary. However, only 65% (73% nationally) of respondents rated their experience of making an appointment as good or very good. The majority of patients we spoke with confirmed they were able to get an urgent appointment at short notice.

We saw steps had been taken to address the capacity issues. The practice had commissioned an external organisation 'Primary Care Foundation' (a company which supports the development of best practice in primary care) to review access arrangements. New ways of working were implemented, including triaging all requests for emergency appointments and home visits to assess urgency. The appointments system was also changed, with more pre-bookable appointments available and increased use of the nursing team. Information was provided to patients about the new system and advice about what to do if they had a minor illness which would not normally require them to be seen by a clinician.

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,

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 local out of hours provider was GatDoc.

We found the practice had an up to date booklet which provided information about the services provided, contact details and repeat prescriptions. The practice also had a clear, easy to navigate website which contained detailed information to support patients.

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. The complaints policy was outlined in the practice leaflet and was available on the practice's website.

None of the 13 patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice. In addition, none of the 24 CQC comment cards completed by patients indicated they had felt the need to make a complaint.

Staff we spoke with were aware of the complaints policy. They told us they would deal with minor matters straight away, but would inform the practice manager of any complaints made to them. Patients could therefore be supported to make a complaint or comment if they wanted to.

The practice had received nine formal complaints in the 12 months prior to our inspection and 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. Staff we spoke with felt involved in the process.

We looked at some of the complaints the practice had received. We saw these had all been thoroughly investigated. The complainant had been communicated with throughout the process and the practice apologised when they did not do as well as they should have done. We saw the clinicians involved had reviewed what had happened and what could be learnt to prevent a reoccurrence. For example, reception staff had received customer care training following a complaint.

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 mission statement was outlined on the practice website and was 'We aim to provide high quality health services that balance continuity of care with good access and resources responsive to patient needs in a caring environment'.

Staff told us they knew and understood what the practice was committed to providing and what their responsibilities were in relation to these aims. They all told us they put the patients first and aimed to provide person-centred care. We saw that the regular staff meetings helped to ensure the vision and values were being upheld within the practice.

Quarterly strategic planning meetings were attended by the GP partners and the practice manager. In addition, an annual practice partners meeting took place to review any changes that needed to be made to take account of contractual changes in the GP contract. These meetings were also used to reaffirm what the practice did well, what its priorities were for the year ahead, and what changes needed to be made to make further improvements to patient outcomes. The practice values had been updated and were going to be discussed with staff at the next full practice 'Time In' session.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. These were available to staff via the shared drive on any computer within the practice. All of the policies and procedures we looked at had been reviewed regularly and were up-to-date.

There was a management team in place to oversee the practice. The practice held regular governance meetings where matters such as performance, quality and risks were discussed. The practice used the Quality and Outcomes Framework (QOF) as an aid to measure their performance. A QOF 'working group' had been set up to monitor performance. The practice had achieved an overall QOF score of 96.5% of the maximum points available in 2013/2014; this achievement was above both the local Clinical Commissioning Group (CCG) and the national averages (95.3% and 93.5% respectively). This confirmed the practice had delivered care and treatment in line with expected national standards.

The practice manager and GPs actively encouraged staff to be involved in development of guidelines and practice procedures. This was confirmed when we spoke with staff, they were able to give examples of where they had made suggestions and these had been acted upon. We found that staff felt comfortable to challenge existing arrangements and looked to continuously improve the service being offered.

The practice participated in an external peer review with other practices in Gateshead CCG, in order to compare data and identify areas for improvement (peer review enables practices to access feedback from colleagues about how well they are performing against each other and national standards). There was a system in place for completing clinical audit cycles. Examples of completed clinical audits included; a review of medication prescribed to children with asthma and infection rates in minor surgery. Both of these audits resulted in changes in practice by clinical staff. A number of internal reviews had been completed, including regular infection control audits and a review of reception arrangements. Several improvements were made following this review, including the introduction of named mentors for new members of staff.

There were well established information governance arrangements in place. For example, all medical students were guided through the policies at the start of their placement. Staff told us the local university had commented positively on these systems.

Staff told us they were aware of the decision making process. Their roles were discussed during appraisals and staff were clear what they were accountable for. For example, staff who worked within reception demonstrated to us they were aware of what they could and couldn't do with regards to requests for home visits.

Leadership, openness and transparency

The practice had a clear leadership structure designed to support transparency and openness. There was a well-established management team with clear allocation of responsibilities. For example, one of the GP partners was the lead for safeguarding, and another was the mental health lead. We spoke with staff from different teams; they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Are services well-led?

Good

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

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the managers were visible and accessible. Managers had a good understanding of, and were sensitive to, the issues which affected patients and staff. A 'buddy' system had been introduced throughout the practice. A member of the administration team was partnered with one of the GPs to ensure they each understood the other's work and maintained clear lines of communication. Staff told us this worked well and was beneficial to them and patients.

Records showed that regular meetings took place for all staff groups. The practice manager told us that they met with the GPs every other week and information from these meetings was shared with staff. Staff told us that the GPs, practice manager and team leaders were very supportive. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals.

GPs told us they usually had a daily catch up at lunchtime. They said these meetings had not taken place recently as they were spending more time familiarising themselves with the new computer system.

We found the practice learned from incidents and near misses. Significant events meetings were held where such issues were discussed. Lessons learned from these discussions were shared with the relevant team members.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had made arrangements to seek and act on feedback from patients and staff. The assistant practice manager told us they had been proactive in seeking feedback. There was a section on the website where patients could submit comments or suggestions, a Facebook page and a suggestion box in the waiting room.

There was an active patient participation group (PPG) open to all patients. The PPG contained representatives from some of the key population groups. The practice actively sought representation from younger people by visiting local schools and attending the mother and baby clinic. The PPG met regularly and representatives from the practice always attended to support the group. We spoke with two members of the PPG and they felt the practice supported them fully with their work and took on board and acted on any concerns they raised.

As a result of the PPG discussions various public information sessions were arranged for practice patients. This included presentations from external experts on strokes and managing asthma.

The practice worked with an organisation called Altogether Better and had signed up to the Health Champions initiative, a project supported by NHS England and the Big Lottery Fund. A number of patients volunteered and had been trained to be Practice Health Champions (Practice Health Champions are people who voluntarily give their time to work with the staff in their local GP Practice or surgery to find new ways to improve the services that the practice offers, and to help to meet the health needs of patients and the wider community).

We spoke with two Practice Health Champions on the day of our inspection and saw the work they were involved in. They had a designated area in the waiting room and we observed them showing patients how to use the self-check in service and encourage them to provide feedback. A practice survey was in progress and the Champions supported patients to complete those questionnaires, as well as the recently introduced NHS Friends and Family tests. The Practice Health Champions were very positive about the staff at the practice and told us they were keen to listen to their ideas and suggestions.

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff we spoke with told us their regular meetings provided them with an opportunity to share information, changes or action points. They confirmed they felt involved and engaged in the running of the practice.

The practice had whistleblowing procedures and a detailed policy in place. Staff we spoke with were all able to explain how they would report any such concerns. They were all confident that concerns would be acted upon.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place.

Are services well-led?

Good

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

Staff from the practice also attended the monthly CCG protected learning time (Time In, Time Out) initiative. This provided the team with dedicated time for learning and development.

The practice demonstrated its strong commitment to learning by providing opportunities for medical students to complete training placements at the practice. The practice was a well-established GP training practice. Only approved training practices can employ GP registrars and the practice must have at least one approved GP trainer. A GP registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice.

The management team met monthly to discuss any significant incidents that had occurred. Reviews of significant events and other incidents had been completed and shared these with staff. Staff meeting minutes showed these events and any actions taken to reduce the risk of them happening again were discussed.

The practice manager met monthly with other practice managers in the area and shared learning and experiences from these meetings with colleagues. We saw minutes of recent meetings, these covered topics including what to expect during a CQC inspection and suggestions for topics to cover at the Time In, Time Out sessions. GPs met with colleagues at locality and CCG meetings. They also attended learning events and shared information from these with the other GPs in the practice.