Birtley Medical Group

Quality Report

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Date of inspection visit: 13 January 2015
Date of publication: 08/05/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Birtley Medical Group on 13 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for the following population groups: 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).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they were able to get an appointment with a GP when they needed one, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which they acted on.

However there was one area of practice where the provider needs to make improvements.

The provider should

Summary of findings

- Ensure that all clinical audits completed measure whether agreed standards are being achieved, and make recommendations and take action where standards are not being met. Three of the seven audits we reviewed included repeat audit cycles, where the practice was able to demonstrate the changes resulting since the initial audits had been carried out.

  Not all of the clinical audits completed measured whether agreed standards had been achieved or made recommendations and took action where standards were not being met.

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 was enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring its effectiveness and had achieved 95.9% of the points available. This was slightly higher than the local and national averages. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for staff. Staff worked with multidisciplinary teams which helped to provide effective care and treatment. Not all of the clinical audits completed measured whether agreed standards had been achieved or made recommendations and took action where standards were not being met.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice in line with others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They reviewed the needs of their local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Most

Summary of findings

patients said they found it easy to make an appointment with a GP, 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. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. They had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which they acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in 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 held community based flu clinics and also offered immunisations for pneumonia and shingles. The practice maintained a palliative care register and supported its older patients to improve their self-care skills.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Patients at high risk of hospital admission had a named GP and structured reviews to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were in line with local averages for all standard childhood immunisations. For example, Infant Men C vaccination rates for two year old children were 96.9% compared to 97.0% locally; and for five year old children were 96.6% compared to 95.9% locally. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours

Summary of findings

and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Cervical screening rates for women aged 25-64 were slightly above the national average at 82.3%, compared to 81.9% nationally.

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 reflects the needs for this age group. GP appointments could be booked in advance online and the practice was looking to introduce this service for nurse appointments in the future.

The practice offered extended opening hours. Appointments were available from 7.15am Monday to Friday and until 7.20pm Monday to Thursday; the practice closed at 6pm on Friday. This made it easier for people of working age to get access to the service.

People whose circumstances may make them vulnerable

Good

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

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice were signed up to the Drug and Alcohol Enhanced Service and one of the GPs had completed extra training to support patients in this area.

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). The practice

Summary of findings

regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. They carried out advance care planning for patients with dementia. The practice had close working relationships with four local nursing and residential care homes and had good knowledge of individual patient's needs. GPs completed weekly ward rounds at each of these homes.

The practice had sign-posted patients experiencing poor mental health to various support groups and organisations. Information and leaflets about services were made available to patients within the practice. Counselling clinics were run by other services from rooms within the practice, which helped to make this service accessible to the practice's patients.

Summary of findings

What people who use the service say

All the 12 patients we spoke with were complimentary about the services they received at the practice. They told us the staff who worked there were 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 patients were not as satisfied.

We reviewed 35 CQC comment cards completed by patients prior to the inspection. The large majority were complimentary about the practice, staff who worked there and the quality of service and care provided. Of the 35 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', 'considerate', 'friendly', 'polite', 'caring' and 'respectful'. Three of the patients who completed CQC comment cards said that at times, the reception staff had been a little less respectful than they would have liked.

The latest National GP Patient Survey showed patients were mostly satisfied with the services the practice offered. The results were mainly in line with or a little below other GP practices within the local Clinical Commissioning Group (CCG) area. The results were:

- The proportion of respondents who would recommend the surgery to somebody new in the area – 68% (CCG average 84%);
- The proportion of respondents who were able to get an appointment to see or speak to someone the last time they tried – 84% (CCG average 87%);
- The proportion of respondents who said the last appointment they got was convenient – 89% (CCG average 93%);
- The proportion of respondents who were satisfied with the surgery's opening hours – 80% (CCG average 80%)
- The proportion of respondents who find it easy to get through to this surgery by phone – 70% (CCG average 78%);
- The proportion of respondents who described their overall experience of this surgery as good – 77% (CCG average 90%)

These results were based on 105 surveys that were returned from a total of 278 sent out; a response rate of 38%.

When we spoke with the practice staff about this, they were surprised as it did not correspond with feedback they had collected from patients themselves. We saw patient feedback collected by a number of GPs as part of their appraisal process was very positive.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that all clinical audits completed measure whether agreed standards are being achieved, and make recommendations and take action where standards are not being met. Three of the seven audits we reviewed included repeat audit cycles, where the practice was able to demonstrate the changes resulting since the initial audits had been carried out. Not all of the clinical audits completed measured whether agreed standards had been achieved or made recommendations and took action where standards were not being met.

Birtley Medical Group

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 two specialist advisors; one with experience of practice management and one with experience of practice nursing.

Background to Birtley Medical Group

The practice is located just off Durham Road in Birtley. The practice serves those living in Birtley and the surrounding areas, including Kibblesworth and Ouston. The practice provides services from the following address and this is where we carried out the inspection:

Durham Road, Birtley, Tyne and Wear, DH3 2QT

The practice provides all of its services to patients at ground floor level, and some offices for staff are on the first floor. The practice offers on-site parking including four disabled parking bays, accessible WC's and step-free access. The practice provides services to around 15,900 patients of all ages based on a Personal Medical Services (PMS) contract agreement for general practice.

The practice has five GP partners and the practice manager is also a partner. There are also 10 salaried GPs, two GP registrars (fully-qualified doctors who spend time working in a practice to develop their skills in general practice), two nurse practitioners, three practice nurses, three healthcare assistants and a team of administrative support staff.

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

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:

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 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 13 January 2015. We visited the practice's surgery in Birtley. We spoke with 12 patients and a range of staff from the practice. We spoke with the practice manager, four GPs, a GP registrar, a nurse practitioner, a practice nurse, 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 35 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

When we first registered this practice in April 2013, the practice declared a number of areas where they felt they were not fully compliant with the regulations at that time. They sent us an action plan that described the actions they would take to become compliant. At this inspection, the practice was able to demonstrate they had completed the actions stated in their action plan.

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 and 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 broken down. This had compromised the safety of some childhood vaccines, which we saw had been disposed of and replaced in line with practice protocols. As a result the practice nurses who would have given the vaccines were informed and the fridges were serviced in order to minimise the risk of re-occurrence.

The practice used the CCG-wide Safeguard Incident Reporting Management System (SIRMS) to record incidents and provide feedback on patient's experiences of care within other services in the local area.

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.

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 and near misses were discussed weekly at meetings attended by GPs, the lead nurse and others who were involved. 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 tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example staff had been reminded of the practice's lone working policies. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were received into the practice electronically by the practice manager. The alerts were reviewed and sent to the administration team to be uploaded onto the practice's intranet system. Staff were informed when new safety alerts had been uploaded into the designated area of the intranet. The practice also maintained an alerts register that staff could refer to. Staff we spoke with were aware of these systems and were able to give examples of recent alerts relevant to the care they were responsible for. Staff said alerts were also discussed at meetings to ensure they were aware of any relevant to their area of work and where action needed to be taken.

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 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, children subject to child protection plans.

A chaperone policy was in place and notices were 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. Non-clinical staff who carried out chaperone duties had undergone a Disclosure and Barring Service (DBS) criminal record check. The names of these staff were displayed next to the main entrance so that patient's knew their names.

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. 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. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that nurses had received appropriate training to administer vaccines.

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 blank prescription forms were stored securely. The arrangements were in line with best practice guidance issued by NHS Protect. We saw records of blank prescription form serial numbers were recorded. We were told a record keeping system was being developed to include those prescription pads kept in the GPs bags.

Cleanliness & Infection Control

We saw the premises were clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Daily and monthly checks on the quality of cleaning were completed and reported back to the cleaning staff. 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 attended local infection control link nurse meetings to enable them to provide advice on infection control to the practice. All staff received induction training about infection control specific to their role, and thereafter updates were provided internally or at 'Time-Out' training sessions.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement infection control 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 and the disposal and management of clinical waste.

Good

Are services safe?

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 (DBS). The practice had a recruitment policy that set out the standards they 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. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There were arrangements in place for members of staff to cover each other's annual leave. The practice manager said the practice rarely used a locum GP agency, as their own GPs were able to cover for each other.

Staff told us there was 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.

Identified risks had been recorded and each risk was assessed with mitigating actions noted to manage the risk. We saw where risks had been identified; action plans had been drawn up to reduce these risks. For example, guidance had been produced for staff to follow when working with substances which had the potential to be hazardous to their health, for manual handling and for working at height.

Staff were able to identify and respond to changing risks to patients, including deteriorating health and medical emergencies. For example, 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 staff had received training in basic life support. Emergency equipment was available. This included a defibrillator (used to attempt to restart a person's heart in an emergency) and oxygen. Records of weekly checks of the defibrillator and oxygen were up-to-date. All the staff we 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. Medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. 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. The plan was due to be reviewed in February 2015. Risks were identified and mitigating actions recorded

Good

Are services safe?

to reduce and manage the risk. Risks identified included power failure and loss of access to the building. All of the partners had a copy of the document, as did the estates and accounts manager.

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.

GPs and nurses led in specialist clinical areas such as sexual health, diabetes and minor surgery. 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.

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 the clinical staff 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 unless there was a clinical reason for doing so.

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 and other monitoring.

The practice were able to show us some clinical audits that had been completed. Not all of the clinical audits completed measured whether agreed standards had been achieved or made recommendations and took action where standards were not being met. We looked at seven examples of clinical audits that had been undertaken in the last few years. Three 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 splenectomy audits in 2006, 2009 and 2014 to check that patients with splenectomy had received a full and up to date course of appropriate immunisations. The results showed improvements had been made with immunisation rates for two of the three recommended immunisations. The audit had been recommended to be repeated again to review the effectiveness of the monitoring systems.

The team was making use of staff meetings to monitor and 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 Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. The Quality and Outcomes Framework is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually. The practice had achieved 95.9% of the points available in 2013/14, which included all of the points available for heart failure and asthma. As part of the on-going review of QOF performance, the practice had identified that the number of medication reviews completed had dropped since the current electronic patient records system used had been introduced. This had resulted in an audit of patient records which led to a review of the practice's prescribing policy. A re-audit was planned to review if the percentage of patients who had received a medication review had increased.

The practice also had a number of improvement plans in place. For example, they had done some work on reviewing

Good

Are services effective?

(for example, treatment is effective)

and improving patient's access to nurse appointments. Workshops had been completed with the nurses with the objective of making best use of their clinical time. This included the completion of time-motion studies by the nurses. An implementation plan had been designed, with plans in to introduce changes in three stages during 2015.

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. The practice had a comprehensive induction pack in place for trainees who were placed there. Feedback from the trainee we spoke with was positive. We also spoke with reception staff who told us they had completed an induction programme when they joined the practice.

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.

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 GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

GPs told us they worked well together as a team. An example of this was the buddy system in place for the review of test results should the patient's regular GP be absent from work for any reason. Weekly meetings for GPs were also held and were used to discuss cases. Monthly meetings were held to discuss any patients who were in receipt of palliative care.

The practice held multidisciplinary meetings on a regular basis to discuss the needs of high risk patients, for example, those with end of life care needs. These meetings were attended by a range of healthcare professionals, including district nurses and palliative care nurses, and decisions about care planning were recorded. The practice's GPs and nurses 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 four local care and nursing homes and GPs completed weekly ward rounds at each of these. They also worked closely with the local Primary Care Mental Health Team (PCMHT) who held clinics at the practice. Representatives from the PCMHT also attended practice meetings.

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 had a 'Team Champion' in place for Choose and Book to lead on this specific area. The practice also shared relevant information, with the consent of their patients, with out-of-hour's services.

Good

Are services effective?

(for example, treatment is effective)

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). 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 we 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 new patients a consultation with a Healthcare Assistant. This 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. 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 immunisations was in line with averages for the Clinical Commissioning Group (CCG). For example, Infant Men C vaccination rates for two year old children were 96.9% compared to 97.0% across the CCG; and for five year old children were 96.6% compared to 95.9% across the CCG.

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. 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 stress, strokes and cancer. The practice's website included links to a range of patient information, including for smoking cessation, weight management and sexual health.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with said they were treated with respect and dignity by the practice staff. Comments left by patients on Care Quality Commission (CQC) comment cards mostly reflected this. Of the 35 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', 'considerate', 'friendly', 'polite', 'caring' and 'respectful'. Three of the patients who completed CQC comment cards said that at times, the reception staff had been a little less respectful than they would have liked. This was not reflected in patient feedback that had been collected by the GPs as part of their appraisal process.

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. We saw that any issues raised by patients were handled appropriately and the staff involved remained polite and courteous at all times.

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. The practice had a small 'screened off' area to the side of the main reception desk. We were told this was made available to patients if they wanted to speak about matters in a more private setting. A computer, desk and chair was also present in this area for patients to use when making 'Choose and Book' appointments. 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 this was updated annually.

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 89% of practice respondents said the GP was good at listening to them and 88% had confidence and trust in the last nurse they saw or spoke to. Both these results were only slightly lower than the local Clinical Commissioning Group (CCG) area averages, which were both 90%.

The majority of the most recently published National GP Patient Survey results for the practice were a little below the local CCG area averages. For example, 72% of respondents said they last GP they saw or spoke to was good at involving them in decisions about their care, compared to the local CCG average of 77%. When we spoke with the practice staff about this, they were surprised as it did not correspond with feedback they had collected from patients themselves. We saw patient feedback collected by a number of GPs as part of their appraisal process was very positive.

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.

The practice had identified its most at risk and vulnerable patients. A total of 293 patients had been identified as being at high risk of hospital admission. The practice had contacted these patients and with their involvement and

Good

Are services caring?

agreement, had put agreed care plans in place. These care plans were reviewed after 3 months to make sure they still met the needs of the patients. Each of these patients were identified on the practice's electronic system.

Staff told us that translation services were available for patients who did not have English as a first language. We also saw that support was available for patients with hearing difficulties and access to a sign language service was advertised in the patient waiting area.

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 and supportive.

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, information was provided for patients who had caring responsibilities or who were cared for by a family member or friend. The practice maintained a carer's register and had 297 patients registered as such. They were proactive in trying to identify patients with caring responsibilities. Patients who registered with the practice were asked if they had any caring responsibilities. The practice had also identified another 40 patients with caring responsibilities during seasonal flu clinics it had run.

Support was provided to patients during times of need, such as in the event of bereavement. Telephone calls were made to bereaved relatives (if appropriate) at these times to offer support and guidance. Bereavement cards were also sent to families when appropriate. Staff we spoke with in the practice recognised the importance of being sensitive to patients' wishes at these times.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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. For example, if the demand for appointments from patients increased, the practice would cancel or postpone any planned meetings that day in order to increase the number of appointments available.

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 nurses was the nurse lead for the CCG and the practice was engaged in a local community nursing project.

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Staff we spoke with said patients were encouraged to see the same GP if possible, which enabled good continuity of care. 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 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 at least twice a year. The practice produced an annual report on work completed in partnership with the group. Actions had been agreed with the group based on a number of identified priorities. Some actions had already been completed. For example, arrangements had been made for staff to park off-site to free up spaces for patients.

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 Monday to Friday and late appointments Monday to Thursday. 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 practice maintained registers for patients with caring responsibilities, patients with learning disabilities and patients receiving palliative care. All of these measures helped to ensure that all of their patients had equal opportunities to access the care, treatment and support they needed.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was situated on the ground and first floors of the building with all services for patients on the ground floor. The main entrance door had been automated to improve access and all of the treatment and consulting rooms could be accessed by those with mobility difficulties. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. This made movement around the practice easier and helped to maintain patients' independence. The patient toilets could be accessed by patients with disabilities, however we saw the alarm chord was not at wheelchair height in either of the patient toilets. 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.

Access to the service

Most of the patients we spoke with and those who filled out Care Quality Commission (CQC) comment cards said they were satisfied with the appointment systems operated by the practice. Comments included 'able to get appointments fairly easily', seem to be able to get appointments fairly quickly' and 'always get an appointment when needed'. A small number of the patients who filled in CQC comment cards were not as satisfied. They made comments such as 'have struggled to get appointments at times', 'sometimes hard to get your own doctor' and 'would like to get an appointment quicker'. We mentioned this to the practice manager and GPs, who said

Good

Are services responsive to people's needs?

(for example, to feedback?)

this feedback would be included as part of the ongoing 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.

Appointments were available from 7.15am Monday to Friday and until 7.20pm Monday to Thursday. The practice closed at 6pm on a Friday. Over 1,000 face to face appointments were made available to patients each week. 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.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to four local care and nursing homes on a specific day each week by a named GP, and to those patients who needed a home visit.

Information was available to patients about appointments on the practice website. This included being able to book appointments with GPs online and information on how to arrange appointments and home visits. The practice manager said they were hoping to introduce online booking for nurse appointments in the future.

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 service for patients requiring urgent medical attention out-of-hours was provided by the 111 service and Gateshead Community Based Care Limited, which is also known locally as GatDoc.

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. Information about services and how to complain was available and easy to understand.

We saw the practice had received 39 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 'comments and suggestion box' in place in the foyer at the entrance to the practice for patients to use.

None of the 12 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 35 CQC comment cards completed by patients indicated they had raised a complaint with the practice.

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. We found details of the vision and practice values were part of the practice's patient charter and business plan. The practice vision and values included to offer a patient focused, supportive and caring service that was accessible to all patients.

We spoke with a variety of practice staff including the practice manager, four GPs, a GP registrar, a nurse practitioner, a practice nurse, a health care assistant and some of the practice's administrative and support staff. They all knew and shared the practice's vision and values and knew what their responsibilities were in relation to these.

Governance Arrangements

The practice had policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at sample of these policies and procedures and saw evidence staff had read and understood these. All of the policies and procedures we looked at had been reviewed regularly and were up to date.

The practice used the Quality and Outcomes Framework (QOF) as a means to measure its performance. The QOF data for this practice showed it was performing slightly above national standards. We saw that QOF data was regularly discussed at practice meetings and actions were taken to maintain or improve outcomes. For example, the practice was looking to increase the number of NHS Health Checks completed to help with its identification of patients with long term conditions.

The practice manager regularly used benchmarking to monitor the performance of the practice in comparison to other practices. This included practices within the local Clinical Commissioning Group (CCG) area and those they were in contact with via email groups.

The practice had completed a number of clinical audits which it used to monitor quality and systems to identify where action should be taken. Not all of the clinical audits completed measured whether agreed standards had been achieved or made recommendations and took action where standards were not being met. We found the practice did not keep a central log of clinical audits completed, as each GP kept records of their own audit activity. A GP we spoke with said the results of completed audits were presented to and discussed with their colleagues at the weekly GP meetings.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a range of potential issues. We saw that risks were regularly discussed at practice meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and actions to mitigate these risks had been put into place.

The practice held regular partners meetings and management meetings. We looked at minutes from some of these meetings and found that performance, quality and risks had been discussed. The practice had a mentoring system in place where each salaried GP was allocated a GP partner as mentor. Practice nurses received monthly supervision from the Nurse Practitioner, who in turn received supervision from a GP.

Leadership, openness and transparency

There was a clear leadership structure with 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 safeguarding. We spoke with a range of staff and 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.

We found there were high levels of staff satisfaction. Staff we spoke with were proud of the organisation as a place to work and spoke of the open and honest culture. There were consistently high levels of staff engagement. The practice manager said any changes to policies and procedures were circulated among the staff for comment before being implemented. We saw from minutes that team meetings were held regularly. Staff told us they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example on health and safety and prescribing, which were in place to support staff. We saw policies were available for all staff to access electronically. Staff we spoke with knew where to find the practice's policies if required.

Are services well-led?

Good

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

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. A staff survey had been completed as part of the practice's review into patient access. Staff had been involved in workshops and problem-solving sessions as part of this review.

The staff we spoke with, including the practice manager and GPs told us forward planning was discussed regularly. Succession planning was openly discussed and we saw plans had already been made for the safe handover of responsibilities in the event of some staff retiring in the next few months. 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 at least twice a year 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 practice had made some changes as a result of feedback from the PPG. This included changing the practice's telephone number back to a local number from a premium rate number and making alternative arrangements for staff car parking in order to release spaces in the practice car park for patients. Patient feedback was also routinely reviewed at group meetings, including any actions taken by the practice in response.

The practice also sought feedback from patients by completing its own patient surveys; the most recent of which was completed in October and November 2014. The survey focused on services provided by the practice's nurses and results from this survey were positive. The practice had also started to analyse their friends and family test results, which was introduced into general practice in December 2014. Results from feedback received in December 2014 showed 93% of patients who responded would recommend the practice to their friends and family.

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 handled consistently, 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 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.

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 Clinical Commissioning Group (CCG) meetings. They attended learning events and shared information from these with the other GPs in the practice. Clinicians regularly fed back to their colleagues after attending educational meetings and CCG-led 'Time Out'

Are services well-led?

Good

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

training events. Nursing staff we spoke with said they attended a monthly CCG wide practice nurse forum which provided them with further education and support. For example, the nursing staff had developed a checklist to follow for urine analysis as a result of learning from working with a local hospital.

Information and learning was shared verbally between staff and the practice also used their intranet system to store and share information. Learning needs were identified through the appraisal process and staff were supported with their development. For example, one of the nursing team had wanted to develop in their role by qualifying as a prescriber, so the practice had funded and supported their training in this area.

Improvements achieved across the practice were recognised and celebrated with staff. For example, improvements achieved as part of the review into patient access the practice had completed were shared and celebrated with the staff team.