Redburn Park Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Redburn Park Medical Centre on 24 March 2015. Overall the practice is rated as outstanding for providing responsive services and for being well-led They are rated good for providing safe, effective and caring services. An innovative, caring, effective, responsive and well-led service is provided that meets the needs of the population served.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised, external agencies were informed of the outcome if they were involved. There were strong comprehensive safety systems in place.
- The practice had scored very well on clinical indicators within the quality outcomes framework (QOF). They achieved 99.9% for the year 2013/14, which was above the average in England of 94.2%. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Patients commented that they thought they received a very good service from the practice.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Patients we spoke with and comments cards indicated that it was relatively easy to obtain an appointment.
- The practice had a clear vision which had quality and safety as its top priority. The practice had a six monthly strategic action plan in place which was monitored using QOF, patient surveys and staff feedback. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

Summary of findings

- The practice offered services which were planned and delivered to meet patient's needs. For example, they recognised they had higher levels of teenage pregnancy. They trained staff and ensured they had accessible services which were available for this group of patients, including access to a dedicated midwife, who could offer support.
- The practice were committed to the care of patients experiencing dementia. They had the highest dementia diagnosis rate in the clinical commissioning group (CCG) area. The CCG target was 66.7% and the practice achieved 100%, the CCG had complimented the practice in achieving this. To validate the dementia register the practice used their computer systems and were able to identify any patients who may be missing from the register and needing support, for example, patients with memory loss, this helped to make their register as accurate as it could be.
- The practice provided a practice approach to understanding the needs of those experiencing severe mental health. They had the highest prevalence of those experiencing severe mental health in the CCG area; however had the highest percentage in the area for performing reviews for these patients, 98.1% (England and CCG averages 75%). They also provided monitoring for patients who failed to attend secondary care appointments with severe mental health who had been discharged from their care in conjunction with the community matron.

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. Patients and staff were protected by strong comprehensive safety systems. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were strong systems in place to ensure there were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. We found systems were in place to ensure that all clinicians were up to date with both NICE guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the CCG, for example their QOF score was 99.9% for 2013/14. The practice had the highest dementia diagnosis rate in the clinical commissioning group area, the CCG target was 66.7% and the practice achieved 100%. The practice was using innovative and proactive methods to improve patient outcomes and they linked with other local providers to share best practice. The practice was a research practice and because of this patients were able to access extra services. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice were able to show us examples of staff appraisals. Staff worked well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice much higher than others for almost all aspects of care. For example the proportion of patients who said their GP was good or very good at treating them with care and concern was 96.1%; the national average was 85%. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this.

Summary of findings

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. They knew the needs of the local population well and engaged with the NHS England Area Team and CCG to secure service improvements where these had been identified. They acted on suggestions for improvements and changed the way they delivered services in response to feedback from their virtual patient participation group (PPG) this is a group of patients who provide their views via email or letter to the practice. They had improved services for teenagers and provided medicals for the oil and gas industry following feedback from patients. Patients told us it was easy to obtain an appointment, with continuity of care and 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 the practice responded quickly when issues were raised.

Are services well-led?

Outstanding

The practice is rated as outstanding for providing well-led services. The practice had a clear vision with quality and safety as its top priority. There was a managerial lead GP who had been in this role for over 25 years and the culture was one of continuous improvement. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients and they had a virtual PPG.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. Patients over the age of 75 had a named GP and were offered a health check. The district nurses carried out assessments of high risk housebound patients. The practice had a linked nursing home for people with dementia, the patients who lived there had one of the GPs as their named GP. All 18 patients had care plans in place and a routine 'ward round' was carried out by the lead GP every two weeks with additional phone reviews and targeted visits, as indicated, to review any issues. Screening for depression was carried out in elderly patients if felt appropriate, in order to gain support and treatment for them.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long term conditions. Patients with long term conditions were regularly reviewed by a clinician, patients had an individual care plan which took account of their wishes for their treatment. Longer appointments were offered for chronic disease reviews. Practice nurses had received extended training in management of chronic diseases. Patients with diabetes received information on their recent blood glucose control, blood pressure and cholesterol to help them understand their condition.

The practice was a Royal College of General Practitioners (RGCP) accredited research practice. The practice were carrying out a project to research whether there was a genetic risk in diabetics. They had carried out research into the formulation of a diabetic care programme and retinal screening was available for diabetic patients every two months in the practice. When diabetes was diagnosed in a patient in the practice training on self-care was delivered to the patient by the practice nurse and dietician. The practice nurses had received training in the management of patients with diabetes training. Patients with a diagnosis of diabetes with impaired glucose received a six monthly review with the practice nurse.

Families, children and young people

Outstanding ☆

The practice is rated as outstanding for the care of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. The practice had a close working relationship with the local health visiting team who attended the weekly

Summary of findings

multi-disciplinary team meeting at the practice to discuss children and families where there were safeguarding or other concerns. The practice also held quarterly meetings specifically to discuss safeguarding. The practice offered weekly child health clinics for children under the age of five in conjunction with the health visitor, practice nurse and a GP; immunisations were available for all children every week. There was also a weekly antenatal clinic. Nationally reported data for 2013/14 showed the practice offered child development checks at intervals that were consistent with national guidelines. The practice were aware of the children in the practice who were subject to child protection plans and there were flagged alerts for staff on the practice computer system. The practice provided service particularly to meet the needs of teenagers and had sought feedback from them in the planning of these services.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the care of the working-age people (including those recently retired and students). The needs of this group 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 offered a full range of clinics; these included contraceptive services, cervical smear screening and smoking cessation and management of long term conditions. There was information on the practice website regarding travel and flu vaccination requirements. NHS health checks were offered for patients aged 40 -74. There were other clinics available at the practice which were held by other healthcare professionals for example, physiotherapy and dietician. The practice had a number of patients working in the offshore oil and gas industry and offered offshore industry medicals for patients at convenient times through the week.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability and they were recalled to reviews which were adjusted to suit individual patient's needs. Patients who did not attend were actively followed up and given an appointment time to reflect complexity. The records of patients who were visually or hearing impaired were marked with alerts on their records to ensure they received the appropriate support when they visited the surgery. They worked closely with social services and the police in identifying and raising concerns about adult safeguarding issues for vulnerable patients. There were a number of patients

seeking gender re-assignment registered with the practice and staff were aware of their preferences and as to how they wished to be addressed in the surgery. They used alerts on patient records to ensure staff were aware of patients wishes.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). The practice had a higher than average number of patients with severe mental health diagnoses, however they had the highest percentage in the area for performing reviews for these patients, 98.1% (England and CCG averages 75%). They also provided monitoring for patients who failed to attend secondary care appointments with severe mental health who had been discharged from their care in conjunction with the community matron. If the patient had difficulties in attending home visits were arranged by a clinician or community mental health nurse. The practice had access to 'talking therapies' for patients in house with a counsellor and psychologist. The practice were able to refer patients to a 'social prescribing scheme' which is a partnership between Age UK and MIND where patients can access social and physical activities in the local community. The practice proactively referred patients to a local memory support team if dementia was suspected. The practice had the highest dementia diagnosis rate in the CCG area of 100%, the target was 66.7% and had been commended by the CCG for this.

Summary of findings

What people who use the service say

We spoke with eight patients on the day of our inspection; this included a member of the virtual patient participation group (PPG). We also received comments by email from five members of the virtual PPG. Almost all of the patients were satisfied with the care they received from the practice and said their dignity and privacy was respected. Patients commented that they thought they received a good service from the practice and they found it easy to obtain an appointment.

We reviewed 32 CQC comment cards completed by patients prior to the inspection. Comments were overwhelmingly positive. Common words used by patients included excellent, efficient and professional. Several people commented on the helpfulness of the staff and the caring manner of the GPs and that they felt listened to by the GPs and practice nurses. Several patients said they would recommend the practice to friends and relatives.

The latest GP Patient Survey completed in 2013/14 showed most patients were very satisfied with the services the practice offered. Results were well above the national average. The results were:

- Proportion of respondents who described the overall experience of their GP surgery as good or very good – 98.2% (national average 85.7%)
- Percentage of patients who would recommend the practice – 96.2% (national average 79.1%);
- Percentage of patients satisfied with phone access – 92.8% (national average 75.4%);
- GP Patient Survey satisfaction for opening hours – 91.7% (national average 79.8%).

Outstanding practice

- The practice offered services which were planned and delivered to meet patient's needs. For example, they recognised they had higher levels of teenage pregnancy. They trained staff and ensured they had accessible services which were available for this group of patients, including access to a dedicated midwife, who could offer support.
- The practice were committed to the care of patients experiencing dementia. They had the highest dementia diagnosis rate in the clinical commissioning group (CCG) area. The CCG target was 66.7% and the practice achieved 100%, the CCG had complimented the practice in achieving this. To validate the dementia register the practice used their computer systems and were able to identify any patients who may be missing from the register and needing support, for example, patients with memory loss, this helped to make their register as accurate as it could be.
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Redburn Park Medical Centre

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 specialist advisor, and a specialist advisor with experience of GP practice management.

Background to Redburn Park Medical Centre

The area covered by Redburn Park Medical Centre is primarily North Shields, extending to the West to Churchill Street and Willington Quay, East to the coast, South to the Tyne Tunnel and North to Rake Lane Road, Norham Road North and A1058 Coast Road. The practice provides services from the following address and this is where we carried out the inspection, 15 Station Road, Percy Main, North Shields, Tyne and Wear, NE29 6HT

The surgery is modern and purpose built. The facilities are on the ground floor with disabled access and a large car park.

The index of multiple deprivation (IMD) placed the practice in band two for deprivation, where one is the highest deprived area and six is the least deprived. There were 29 GP practices in the clinical commissioning group (CCG) area and Redburn Park Medical Centre had the highest levels of deprivation.

The practice has higher levels of younger patients, in particular aged 0-4, 4.78% male (national average 3.09%), 4.69% female (national average 2.95%). Aged 25-39, 4.65% male (national average 3.5%), 5.28% female (national average 3.62%). They also have lower numbers of elderly patients compared to the England age distributions of patients, for example, aged 75-79 male 0.64% (national average 1.44%) female 1.11% (national average 1.69%).

The practice has five GPs partners and one GP registrar (a fully qualified doctor allocated to the practice as part of a three-year, general postgraduate medical training programme), Four of the GPs are female and two male. The practice is a training practice. There are two practice nurses and one health care assistant and a vacancy for a treatment room nurse. There is a practice manager and six reception and administrative staff.

The practice provides services to approximately 5,000 patients of all ages. The practice is commissioned to provide services within a General Medical Services (GMS) Agreement with NHS England.

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

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included the local Clinical Commissioning Group (CCG) and NHS England.

We carried out an announced visit on 24 March 2015. During our visit we spoke with a range of staff. This included GPs, practice nurses and reception and administrative staff. We also spoke with eight patients. We reviewed 32 CQC comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

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 January 2015 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.

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.

The practice had a strong comprehensive safety system which used a range of information to identify risks and improve quality in relation to patient safety. This included reported incidents, national patient safety alerts, audits as well as complaints received from patients. For example, the practice had a protocol for clinical and reception staff regarding reducing prescribing risks and GPs reviewed all requests for controlled drugs.

Staff we spoke to were aware of their responsibility to raise concerns, and how to report incidents and near misses. They said there was an individual and collective responsibility to report and record matters of safety. The induction for new staff included an introduction to significant events.

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

Learning and improvement from safety incidents

The practice had a strong system in place for reporting, recording and monitoring significant events. The practice manager and GPs explained to us that one of the GP partners had the responsibility for these and saw them all. We saw records held of these which went back three years. Where incidents and events met the threshold criteria, these were also added to the local CCG Safeguard Incident & Risk Management System (SIRMS). These events and incidents were discussed at weekly multi-disciplinary meetings and there was an annual review of them. We saw some examples of these, details of the event, steps taken, specific action required and learning outcomes and action points were noted. Other agencies were given feedback if they were involved.

The practice manager was the contact for all safety alerts. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. The practice manager passed any clinical safety alerts to a GP partner who was responsible for these. They used the practice computer intranet system 'GP team net' to circulate the alerts to staff. This system had a facility to track who had seen the alerts.

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. One of the GP partners was the safeguarding lead for both adults and children.

Training records we saw confirmed staff had attended training relevant to them. All staff had received adult and child safeguarding training. The child safeguarding lead and the other GPs had received level three child safeguarding training. The practice nurses had received child safeguarding training level two and the administration staff child safeguarding level one training. Safeguarding was part of the induction programme for all staff. GPs had received additional in house training on domestic violence.

We saw minutes which confirmed the practice held a quarterly formal safeguarding meeting with GPs, health visitors, practice nurses, midwife and practice manager. Safeguarding issues were also discussed at the weekly multi-disciplinary team meeting. The practice were aware of the children in the practice who were subject to child protection plans and there were flagged alerts for staff on the practice computer system. They worked closely with social services and the police in identifying and raising concerns about adult safeguarding issues for vulnerable patients.

The practice had higher levels of safeguarding referrals than other practices. They had their own up to date policies for safeguarding adults and children, domestic violence and abuse and protocols for multi-agency risk assessment conferences (MARAC). There were child safeguarding quick reference and pocket guides to assist staff. The

safeguarding lead GP had also carried out an audit to ensure the practice had all the up to date guidance on safeguarding for staff. The practice also produced a document in 2014 'Lessons and Actions from Adult and Child Safeguarding reviews' actions from this included the need for guidance for staff to refer to for domestic violence issues. They developed a designated template to record information for social services for case reviews and case conferences to make it easier for clinicians to deal with the request promptly and effectively.

Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

The practice had a chaperone policy in place which was last updated in November 2013. There were notices in the waiting room informing patients they could request a chaperone if required and the practice policy was displayed. Clinical staff and some administration staff had been trained to carry out chaperoning. We saw all staff who acted as chaperones and had received a disclosure and barring service check (DBS).

Medicines management

We saw there were policies in place for controlled drugs, prescribers and a repeat prescribing protocol which were in line with national guidance.

We checked medicines stored in the treatment rooms and medicine refrigerators and found all medicines were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures and logs of these were kept.

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. Some GPs carried medication in their bags. One of the GPs explained these were checked by the practice nurses. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions which required active monitoring had an audit trail in place. For example, warfarin, lithium and disease-modifying anti-rheumatic drugs (DMARD) were not put on repeat prescription. The GP checked records to ensure recent blood monitoring results had been carried out and that follow up arrangements were in place. Blank prescription forms were handled according to national guidelines and were kept securely. The practice had implemented the Electronic Prescription System (EPS). This enables prescribers, such as GPs and nurses, to send prescriptions electronically to a pharmacy, where this is the patient's preferred choice. The system also helps reduce prescriber errors.

Cleanliness and infection control

We saw the practice 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.

One of the practice nurses was the nominated infection control lead. We saw there was an up-to-date infection control policy and detailed guidance for staff about specific issues including waste management. All of the staff we spoke with about infection control said they knew how to access the practice's infection control policies. There were yearly audits of infection control and a hand hygiene audit carried out in January 2015. The practice nurse had received specific infection control training for clinical staff and all other staff had completed training which included hand washing techniques and specimen handling.

The risk of the spread of inspection 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 room had walls and flooring that was easy to clean. Hand washing instructions were displayed by hand basins and there was a supply of liquid soap and paper hand towels. The privacy curtains in the consultation rooms were changed every six months; there was a schedule in place to monitor this. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades.

The practice had a cleaner employed on site who worked on the days the practice was open. There were cleaning schedules in place with daily, weekly and monthly tasks to ensure the premises remained clean.

The practice manager showed us a legionella risk assessment which had been carried out in 2012. The practice had implemented the recommended checks and tests as a result of this. Legionella is a bacterium found in the environment which can contaminate water systems in buildings.

Good

Are services safe?

Equipment

Staff had access to equipment to safely meet patients' needs. The practice had a range of equipment in place that was appropriate to the service. This included medicine fridges, patient couches, access to a defibrillator and oxygen on the premises, sharps boxes (for the safe disposal of needles) and fire extinguishers.

The practice manager showed us records of calibration of equipment which was carried out by a local contractor. Each piece of equipment was individually listed with records of when they had been serviced or calibrated.

Staffing and recruitment

The practice had a recruitment policy that set out the standards they followed when recruiting clinical and non-clinical staff. Records we looked at were well organised and contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the DBS and medical indemnity insurance. Where DBS checks were not carried out there was a risk assessment in the member of staffs file as to the reason.

Staff told us there were enough staff to maintain the smooth running of the practice and to ensure patients were kept safe. The GPs were able to cover additional sessions during holidays or busy periods, when needed, by altering their working week to meet the demand for appointments. A special rota was put in place for busy periods, for example, over the Christmas period. As far as possible no more than one GP would be absent at any one time. The reception and administration staff covered each other's annual leave. The practice nurses worked part time and were able to increase their hours to cover for each other's absences.

If the practice needed to obtain locum cover they would carry out their own recruitment checks on them and also on GP registrars who worked at the practice. We saw a file which contained checks on a GP registrar who was working in the practice. This included identity checks and checks of professional qualifications and DBS checks. There was also an induction package available for locum GPs and GP registrars.

Monitoring safety and 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. The practice health and safety risk assessment included all rooms in the building including the corridors and toilets.

The practice had developed clear lines of accountability for all aspects of patient care and treatment. The GPs and nurses had lead roles such as safeguarding and infection control. Each GP had responsibility for several clinical areas such as asthma and depression and oversaw care in these areas.

The practice had a staff protocol for managing patients with a medical emergency to ensure an appropriate response. The practice had a chronic disease recall system which was overseen by the practice manager and health care assistant to ensure all patients with a chronic disease were reviewed regularly who were on the registers. There was also a register of housebound patients. A lead GP was identified for each patient who was on the practice palliative care register.

All emergencies in the surgery were reviewed as a significant event. For example, a collapsed patient in waiting room was used as a learning experience to look at how risks could be reduced.

Arrangements to deal with emergencies and major incidents

Emergency equipment was available including access to oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). Staff we spoke with knew where this equipment was kept and confirmed they were trained to use it. They also showed us the emergency medicines which were available in a secure area of the practice, all staff knew of their location. Processes were in place to check whether 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

Good

Are services safe?

the practice. This had been updated in January 2015 and contained relevant contact details for staff to refer to, for example who to contact if the heating system failed. The practice also had an IT continuity plan in case of need.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They used prescribing and clinical protocols and there was a lead GP for each area who reviewed and updated the protocols. The protocols were available on the practice intranet with direct access to guidelines from the National Institute for Health and Care Excellence (NICE) and the clinical commissioning group (CCG). The practice had monthly meetings and worked closely with the CCG developing pathways of care for ear, nose and throat (ENT) and ophthalmology.

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. There were care plans in place for all patients with complex needs. For example, there were care plans in place for those requiring palliative care, with chronic heart failure and who used oxygen. Patients at high risk of admission into hospital also had care plans; the practice used systems called LACE and RAIDR, which are validated scoring systems to identify these patients at high risk of hospital admission. These care plans were reviewed at least three monthly and patients were given a copy of their care plan with details of their medical problems and medication. All of these patients had a summary care record in place with the out of hour's provider to ensure continuity of care should they require it.

All patients over the age of 75 had a named GP and were offered a health check. The district nurses carried out assessments of high risk housebound patients. The practice had one linked nursing home for people with dementia; the patients who lived there had one of the GPs as their named GP. All 18 patients had care plans in place and a routine 'ward round' was carried out by the lead GP every week to review any issues. Staff at the nursing home were able to note any problems they had throughout the week and discuss them with the GP at their weekly visit. Nursing home staff could make use of a rapid telephone response about any queries for patients for example regarding medicines. Screening for depression was carried out for elderly patients if felt appropriate, in order to gain support and treatment for them.

The practice had the highest dementia diagnosis rate in the clinical commissioning group (CCG) area. The CCG target was 66.7% and the practice achieved 100%, the CCG had complimented the practice in achieving this. To validate the dementia register the practice used their computer systems and were able to identify any patients who may be missing from the register and needing support, for example, patients with memory loss, this helped to make their register as accurate as it could be. Patients on the register were seen for an annual review with their carers and received an extended appointment time so issues could be discussed in detail. Reviews were carried out in the patient's home or nursing home if appropriate. Personalised care plans were in place for all patients diagnosed with dementia, which included emergency care plans for any hospital admission.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2013 / 2014. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures. We saw the practice had scored very well on clinical indicators within the QOF. They achieved 99.9% (896.15 out of a maximum of 897, the practice did not have a patient which fell into a category to receive maximum points for which is why they did not receive 100%) which was above the average in England of 94.2%.

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. Clinical staff had received equality and diversity training. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice had an organised system in place for completing clinical audit cycles. They gave us a copy of a

Good

Are services effective?

(for example, treatment is effective)

schedule of audits which went back to 2010. We saw several examples of two cycle audits which had been carried out and the practice could demonstrate that they had improved outcomes for patients over time.

The audits and quality improvement activities which were carried out were over and above those which were required to achieve targets such as QOF. For example, one of the GPs carried out an audit of 500 letters from secondary care referrals to check that the practice worked with other organisations in a safe and effective way. They concluded that they were; there was only one instance where a patient's blood tests were not followed up from the audit.

The practice carried out an audit of osteoporosis prevention in patients with chronic obstructive pulmonary disease (COPD) following NICE guidance. 48 patients were identified. There were two repeat audits which resulted in 38 of the 48 patients at risk of osteoporosis receiving appropriate treatment or a DEXA assessment, which is an assessment of bone mineral density. Without this audit these patients would not have been identified by normal means and no assessment made.

The practice was a Royal College of General Practitioners (RGCP) accredited research practice. The practice were carrying out a project to research whether there was a genetic risk in diabetics. They had carried out research into the formulation of a diabetic care programme and retinal screening was available for diabetic patients every two months in the practice. When diabetes was diagnosed in a patient in the practice training on self-care was delivered to the patient by the practice nurse and dietician. The practice nurses had received training in the management of patients with diabetes training. Patients with a diagnosis of diabetes with impaired glucose received a six monthly review with the practice nurse.

Due to the practice being a research practice patients were able to access extra services. For example, a patient had participated in a Newcastle University trial. They had loss of arm function due to a stroke and were able to receive robot assisted training on their arm to aid recovery.

The practice were 2nd in the CCG area for their cancer diagnosis rate. They reviewed their two week wait referrals for possible cancer retrospectively to see if they could take any learning from the outcomes.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around audit and quality improvement. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

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. The practice manager and health care assistant oversaw recalls for reviews for patients with long-term conditions such as COPD.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records which were comprehensive and saw that staff were up-to-date with attending basic courses such as fire safety. There were weekly protected time meetings with staff for training and feedback.

Clinical staff had received basic training and clinical training appropriate to their role. Clinical staff had an individual development plan. All GPs were up-to-date with their yearly continuing professional development requirements. Clinical staff had protected personal development time and weekly multi-disciplinary team (MDT) meetings which included regular educational activity.

The practice was a training practice, two of the GP partners were GP trainers and they told us they consistently received positive feedback on the quality and level of supervision and the involvement of the whole team in their training from the GP trainee registrars who worked with them. We spoke with a GP registrar who told us they found the GP trainers helpful and approachable. There were arrangements in place for the monitoring of performance and they received clinical supervision which was available daily.

All staff undertook annual appraisals; there was a staff and a GP appraisal policy. Salaried GPs received an appraisal and the practice nurses were appraised by the GP lead for practice nurses.

Good

Are services effective?

(for example, treatment is effective)

Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. Staff confirmed they had protected training time, they felt supported by the practice.

We saw the practice had an induction programme to be used when staff joined the practice. This covered individual areas of responsibility and general logistical information about how the practice operated. A pack had also been developed to support locum GPs with their work.

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 could demonstrate that they worked closely with other services to deliver effective care and treatment across the different patient population groups. For example, they worked closely with the health visitors who were attached to the practice.

The practice had weekly MDT meetings where patients with high risk or complex conditions were discussed. Where possible district nurses, community matrons and health visitors attended. There were quarterly meetings with the palliative care team. We saw minutes of these meetings. The practice felt this system worked well and remarked on the usefulness of the meetings as a means of sharing important information.

There were clear and effective arrangements in place for referral to other services. Information was shared with the out of hours provider to ensure that the whole system approach was co-ordinated. Special patient notes which included complex cases such as palliative care were shared. The practice policy was for safeguarding referrals to be made within 24 hours. The practice maintained a noticeboard where they kept track of hospital admissions. Hospital discharge letters were reviewed on the day they were received. All patients discharged from hospital on the high risk register were contacted within three days to ensure appropriate management plans were in place. All staff we spoke with understood their roles and felt the system in place worked well.

Information sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice mostly made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Patient's relevant clinical records were transferred automatically at the same time. Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times. Laboratory and radiology results were received electronically.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, 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. Medical records were summarised in a timely manner using the practice protocols. All investigations, blood results and X rays, were requested and results received online.

Consent to care and treatment

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. Staff we spoke with told us they ensured they obtained patients' consent to treatment. Staff were able to give examples of how they obtained verbal or implied consent. We also saw a consent to treatment form which the practice used for consent to investigations or specific treatment.

GPs we spoke with showed they were knowledgeable of 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.

Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the Mental Capacity Act (MCA). We found all clinical staff had completed training in the MCA and used it appropriately. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment. They gave us some examples where patients did not have capacity to consent. The GPs told us an assessment of the person's capacity would be carried

out first. If the person was assessed as lacking capacity then a "best interest" discussion needed to be held. They knew these discussions needed to include people who knew and understood the patient, or had legal powers to act on their behalf.

Health promotion and prevention

It was practice policy to offer all new patients a health check. New patients were able to download a pre-registration form and a medical questionnaire from the practice website which, once completed, they could submit electronically, post or hand into the reception team. The healthcare assistant carried out assessments of new patients that covered a range of areas, including past medical history and ongoing medical problems. They also provided blood pressure reviews, blood tests, spirometry (lung tests) smoking cessation advice and diabetic foot checks.

The practice offered a full range of clinics; these included counselling, contraceptive services including the fitting of implants, cervical smear screening, smoking cessation and management of long term conditions. There was information on the practice website regarding travel and flu vaccination requirements. NHS health checks were offered for patients aged 40 -74. The health care assistant who worked at the practice also did some hours as a receptionist and was proactive in encouraging patients to attend clinics for the health checks which the practice offered.

The practice had higher numbers of teenagers on their practice list and offered accessible services for them which included health promotion advice, smoking cessation clinics, advice for teenagers concerned about their weight and support for teenagers worried about bullying, self-harm and exam anxiety.

The QOF data for 2013/14 confirmed the practice obtained 99.7% of the total points available for supporting patients to stop smoking, this was 4.7 points above the local CCG average and 6 points above the England average, using a strategy that included the provision of suitable information and appropriate therapy. The data also showed the practice had obtained 100% of the total points available to them for providing recommended care and treatment for patients diagnosed with obesity. This was in line with the local CCG and England averages. The practice had also obtained 100% of the points available to them for providing cervical screening to women from QOF. This was 0.5 percentage points above the local CCG average and 2.5 points above the England average. They had the third highest achievement in the CCG area for take up of cervical screening despite their high deprivation rate which is associated with low levels of cervical screening uptake. The practice level was 83% (England average 77% and CCG average 79%)

The practice was good at identifying patients who needed additional support and were proactive in offering this. For example, there was a register of all patients with dementia. QOF data for 2013/14 showed that the practice had obtained 100% of the points available to them for providing recommended clinical care and treatment to dementia patients.

The practice had held its first Saturday flu vaccine clinic in 2014 where patients were able to attend to have their annual flu vaccine. They found this successful and it freed up time for routine services through the working week. The practice had the highest vaccination rate in the CCG area for over 65's.

The practice offered weekly child health clinics for children under the age of five in conjunction with the health visitor, practice nurse and a GP; immunisations were available for all children every week. There was also a weekly antenatal clinic. Last year's performance for immunisations was in line with averages for the Clinical Commissioning Group (CCG). For example, infant meningococcal C (Men C) vaccination rates for two year old children were 98.7% compared to 96.8% across the CCG; and for five year old children were 90.2% compared to 92.1% across the CCG.

The practice had a blood pressure monitoring machine in the waiting area. They had loaned out blood pressure monitoring machines for patients to record their blood pressure readings at home for a more accurate diagnosis and treatment.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice regarding patient satisfaction. This included information from the national GP patient survey, data was above all of the national averages. For example, the proportion of patients who described their overall experience of the GP surgery as good or very good was 98.2%, compared to the national average of 85.7%. The proportion of patients who said their GP was good or very good at treating them with care and concern was 96.1%, the national average was 85%. The practice's own survey found the proportion of patients who find the receptionists at the surgery helpful was 98%.

We reviewed 32 CQC comment cards completed by patients prior to the inspection. Comments were overwhelmingly positive. Common words used by patients included excellent, efficient and professional. Several people commented on the helpfulness of the staff and the caring manner of the GPs. Several patients said they would recommend the practice to friends and relatives.

We spoke with eight patients on the day of our inspection; this included a member of the virtual patient participation group (PPG). We also received comment by email from five members of the virtual PPG. Almost all of the patients were satisfied with the care they received from the practice and said their dignity and privacy was respected. Patients commented that they thought they received a good service from the practice.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was seen to be considerate, understanding and caring, while remaining respectful and professional.

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

Staff were aware of the need to keep records secure and had received information governance training. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation. There were policies in place for dignity and respect and confidentiality.

The practice had policies in place to ensure staff and other patients were protected from disrespectful, discriminatory or abusive behaviour.

Care planning and involvement in decisions about care and treatment

Patients told us they felt listened to by the GPs and practice nurses. 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.

From the 2014 National GP Patient Survey, 94% of patients said the GP they visited had been 'good' at involving them in decisions about their care (national average was 81%). The data showed that 96.3% of patients said the practice nurse they visited had been 'good' at involving them in decisions about their care (national average 85.1%)

We asked staff how they made sure that people who did not have English as a first language were kept informed about their treatment. Staff told us they had access to an interpretation service, either in person or by telephone and access to British Sign Language interpreters. The practice had the facility to provide information in an accessible format for patients.

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. Patients also commented they felt staff regularly went beyond the call of duty and exceeded their expectations. For example, when supporting patients and helping them to cope with long term health problems.

Notices in the patient waiting room also signposted people to a number of support groups and organisations. This included MIND for help with mental health issues and the Macmillan service for support following bereavement.

The practice had a register of carers. Carers known to the practice were coded on the computer system so they could be identified and offered support.

Good

Are services caring?

Support was provided to patients during times of bereavement. Families were offered a visit from a GP at these times for support and guidance. The practice manager said this would be the GP who had been involved with the patient and their family in order to maintain continuity of care. Staff were kept aware of patients and families who had been bereaved so they were prepared and ready to offer emotional support. The practice also offered details of bereavement services. Staff we spoke with in the practice recognised the importance of being sensitive to people's wishes.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. The practice recognised there were high levels of deprivation within the area it served, particularly child deprivation. The practice had higher numbers of children and adults under the age of 35 registered at the practice and there was a higher prevalence of those experiencing poor mental health. Patient consultation rates were higher which resulted in a 33% higher workload. Two of the GP partners and most of the staff had worked there for many years. The staff managed to cover absences themselves rather than using locum cover which enabled good continuity of care. The practice had close links with the local community through the different multi-disciplinary meetings.

Two of the GPs were involved locally with the Royal National Lifeboat Institution (RNLI). One GP was the medical officer for the local branch and the other was their deputy. These were voluntary positions which supported a local charity and the community.

The practice recognised it had higher levels of teenage pregnancy and ensured they had accessible services for teenagers. The practice nurse was fully trained in sexual health and also worked a session at their local sexual health clinic. This ensured they were able to provide services which are in line with the latest standards. They offered appointments for all sexual health services throughout the week including fitting contraceptive implants, contraceptive injections, contraceptive pills and screening for sexual infections. The practice had offered a drop in service for teenagers; however feedback from them was that they preferred the anonymity of attending a routine appointment rather than a dedicated clinic. The practice also promoted appointments by telephone via posters in the waiting area and on the practice website for patients if they preferred. There was a dedicated midwife who looked after teenagers who were pregnant and they worked closely together with them to support the teenagers with additional antenatal care and care after the baby was born. There was a dedicated midwife who looked after young women who had a drug or alcohol problem and were pregnant.

The practice offered offshore industry medicals for oil and gas workers at convenient times through the week. The practice was in an area of high unemployment where opportunities for work were beginning to open up in the offshore oil and gas and renewably energy industries. A number of patients asked if they were able to carry out Oil and Gas medicals. Patients said they had to travel all over the country for their medicals which could mean a delay in starting work. One of the GPs researched the professional qualifications and training required, which included attending a training course and identifying a mentor for them to undertake the training. A fee was charged to the patients to cover the time and work involved, this was lower than other companies offering this service. In response to increasing demand a further GP completed their training in the last year. The practice were the only GPs in the CCG area providing this service.

The practice involved other stakeholders in planning services. They had clinics available at the practice which were held by other healthcare professionals for example physiotherapy and dietician. The practice gave the other stakeholders the opportunity to provide feedback on the service they provided to the practice. For example, feedback resulted in the way physiotherapy appointments were booked being changed and a leaflet was produced for patients by the practice with information on the service, leading to improvements in the service for patients. The practice were involved in service planning with the local clinical commissioning group (CCG) in providing a proactive service to a local linked nursing home where all patients the practice had there had the same GP and all 18 patients had care plans in place.

Patients with long term conditions were regularly reviewed by a clinician, patients had an individual care plan which took into account of their wishes for their treatment. The clinicians had access to templates to ensure that patients received a comprehensive review of their conditions. Longer appointments were offered for chronic disease reviews. Practice nurses had received extended training in management of chronic diseases. Patients with diabetes received information on their recent blood glucose control, blood pressure and cholesterol to help them understand their condition.

The practice had struggled to run a patient participation reference group (PPG) due to lack of interest from patients and therefore had an online PPG consisting of 26 patients

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

who were able to provide feedback to the practice on issues. There was a notice in the waiting area and on the practice website explaining what the PPG was for and asking patients if they would like to join. The PPG were involved in the annual patent feedback questionnaire the practice produced. The questions which the PPG said they wanted patients asked about included Christmas opening hours, flu clinics, on-line services and patient self-check and health promotion information. The PPG had influenced the practice into holding an annual flu vaccination clinic where patients who were eligible could go and receive the vaccine.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to telephone or face to face translation services if required, for those patients whose first language was not English.

The practice had the highest prevalence of those experiencing severe mental health in the CCG area, 1.14% (England 0.86%, CCG average 0.78%). They had the highest percentage from the practices in the CCG area for performing reviews for these patients, 98.1% (England and CCG averages 75%). The practice recognised that they had a significant number of patients experiencing severe mental health who did not attend appointments and had been discharged from secondary care as a result of this. They met with the local consultant psychiatrist to discuss the care of these patients. The practice have taken up the care and monitoring of these patients in conjunction with the community matron to ensure they have regular health checks and long term medication. The practice felt that without regular monitoring these patients would be at risk of relapse and require patient care. The practice had access to 'talking therapies' for patients in house with a counsellor and psychologist. The practice were able to refer patients to a 'social prescribing scheme' which is a partnership between Age UK and MIND where patients can access social and physical activities in the local community.

Patients with a learning disability, experiencing poor mental health or dementia were recalled to reviews. These were adjusted to suit individual patients. Patients who did not attend were actively followed up and given an appointment time to reflect complexity. A variety of methods were used to contact and persuade patients to attend for regular reviews including visiting them at home. Alerts were added to patient's records and all staff were aware to prioritise them for appointments and if they presented to the surgery a member of the clinical staff would see them opportunistically. The practice provided support and advice for staff in several local community homes for people with learning disabilities.

The records of patients who were visually or hearing impaired carried alerts on their records to ensure they received the appropriate support when they visited the surgery. An induction loop system was in place for patients who experienced hearing difficulties.

There were a number of patients seeking gender re-assignment registered with the practice and staff were aware of their preferences and as to how they wished to be addressed in the surgery. They used alerts on patient records to ensure staff were aware of patients wishes.

The premises had been designed to meet the needs of people with disabilities. All of the treatment and consulting rooms could be accessed by those with mobility difficulties and the front door opened automatically. The patient toilet could be accessed by patients with disabilities and there were designated disabled parking spaces in the main surgery car park close to the entrance.

The practice had male and female GPs, which gave patients the ability to choose to see a male or female GP if they had a preference.

Access to the service

Patients we spoke with and comments cards indicated that it was easy to obtain an appointment.

Whilst speaking to patients in the waiting room we observed that they did not have a long wait to be seen by the GP or practice nurse and appointments were running to time.

This was reflected in the data from the national GP survey. 92% of patients were satisfied with phone access (national average 75.4%) and the GP Patient Survey satisfaction for opening hours was 91.7%, the national average was 79.8%.

From the practice's own survey of January 2015;

- Proportion of patients who say the last appointment they got was convenient - 99%
- Proportion of patients who describe their experience of making an appointment as good - 89%
- Proportion of patients usually waited 15 minutes or less after their appointment time to be seen - 88%

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- Proportion of patients who find it easy to get through to the surgery by phone - 89%
- Proportion of patients with a preferred GP who usually get to see or speak to that GP - 79%
- Proportion of patients who were able to get an appointment to see or speak to someone the last time they tried - 92%

Appointments were offered Monday to Friday from 8.40am until 5.30pm and the practice open between 8:30am and 6:00pm. Patients were able to book appointments in person, by phone or on-line. Medical emergencies were seen on the day there were appointments available for this and when they were used up patients were given appointments for telephone triage and an appointment would be arranged if necessary. Appointments could be booked in advance. Practice nurse appointments were available to book ahead but there were slots available each day for clinicians to triage patients into for more urgent cases. Although there were no extended opening hours, both the GP National and practice survey data provided feedback that patients were happy with the opening hours the practice provided.

Any delays in appointments or cancellations were fully explained to patients by the reception staff. The patient call system alerted patients to speak to reception if they had waited more than 20 minutes to be seen. The practice had a system to identify patients who needed an emergency appointment, the receptionist contacted the GP on call and if indicated kept the patient on the phone until they had been assessed. Patients were able to book appointments in person, by phone, or online.

Comprehensive information was available to patients about appointments on the practice website and in the patient information leaflet. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The practice offered appointments and repeat prescriptions on-line. Electronic prescriptions were available. They could be ordered direct from the surgery to pharmacy.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. Information regarding how to make a complaint was in a leaflet for patients which set out how to complain and what would happen to the complaint and the options available to the patient.

The practice manager supplied us with a schedule of eight complaints which had been received in the last 12 months and we found these had all been dealt with in a satisfactory manner. We saw minutes from the annual review of complaints meeting.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care to a deprived population in a flexible pragmatic way. It was evident in discussions we had with staff throughout the day that it was a shared vision and was fully embedded.

The practice had a managerial GP who had been in this role for over 25 years and the culture was one of continuous improvement. They had looked at innovative ways to drive the business forward which included the development of the practice intranet site which was very sophisticated. This allowed smarter working for staff, for example, NICE and CCG guidance and templates to assist GPs were held on this system. Some CCGs nationally had adopted the system as best practice.

The practice were also able to offer medicals for the public who worked in the oil and gas industry. The income generated from this enabled them to enabled us to fund an additional treatment room nurse and to be able to increase health care assistant sessions.

The practice had a six monthly strategic action plan in place which was monitored using QOF, patient surveys and staff feedback.

The staff we spoke with, including clinical and non-clinical staff, all knew the provision of high quality care for patients was the practice's main priority. They also knew what their responsibilities were in relation to this and how they played their part in delivering this for patients.

The senior partner was mentoring another GP to develop skills in leadership and understanding of the role of senior partner for succession planning.

Governance arrangements

The practice had numerous policies and procedures in place to govern activity and these were available to staff via the practice intranet on any computer within the practice. We looked at a sample of these policies and procedures. All of the policies and procedures we looked at had been reviewed regularly and were up-to-date. The practice had the ability to discuss patients and services daily. They were able to instantly review the practice's management of a condition if a problem or near miss was identified. The coding of diagnosis and recording of medication meant that searches could be ran straight away if a problem was been found.

Information sharing across teams was given a high priority. There was protected time each week for the GP lead and practice manager to meet to discuss weekly issues and strategic decisions. The practice manager met with the administrative staff weekly to inform them of any changes needed. There were MDT meetings every week and regular GP partner meetings. We saw minutes of these meetings. This helped to ensure that information was shared at the appropriate levels and in a timely manner.

The practice had comprehensive assurance systems and performance measures, which were reported and monitored. They had protocols in place to manage all chronic diseases which were regularly reviewed and updated according to local CCG and NICE guidelines. These included the use of their electronic patient records system. The QOF data for this practice showed it was performing above the averages of the local CCG and across England as a whole. Performance in these areas was monitored by the practice manager and GPs, supported by the administrative staff. The practice had identified clinical leads for many of the QOF areas, for example diabetes or epilepsy, had clinical leads allocated to them. We saw that QOF data was regularly discussed at team meetings. Lead GPs had also been identified for many of the additional and enhanced services the practice provided.

There was a systematic programme of clinical and internal audit, which was used to monitor quality and identify where action was needed. The practice had completed a number of clinical audits in the last year, for example in relation to vitamin B prescribing, management of bacteriuria (the presence of bacteria in urine) in pregnancy, and breast screening. The results of these audits demonstrated outcomes for patients had improved.

There were comprehensive arrangements for identifying, recording and managing risks, issues and mitigating actions. Incident reporting was encouraged and was reviewed frequently at all levels across the practice.

Leadership, openness and transparency

The practice had a clear leadership structure which had named members of staff in lead roles. For example, there were lead GPs in areas such as safeguarding. We spoke with

Are services well-led?

Outstanding ☆

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

staff throughout the practice, both clinical and non-clinical; they were all clear about their own roles and responsibilities. They also knew who the nominated leads were across the practice. We found there were high levels of staff satisfaction. Staff were openly proud of the organisation as a place to work, spoke highly of the open and honest culture, they felt they had a good relationship with the patients. The last four appointed GPs were all previous GP registrars at the practice who had no hesitation in coming back to work permanently at the practice. There were consistently high levels of staff engagement.

Staff we spoke with and records we saw showed that staff meetings were held regularly. Staff said they felt actively encouraged to raise any concerns and suggestions for improvement they had.

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

Practice seeks and acts on feedback from its patients, the 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. They said these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We saw the practice also used the meetings to share information about any changes or action they were taking to improve the service and they actively encouraged staff to discuss these points. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a virtual patient participation group (PPG); this is a group of patients who provide their views via email or letter to the practice. They worked together with the group to produce questions for the latest survey of patients. Feedback from patients was encouraged and we saw the practice shared this feedback regularly with staff. This included when there were lessons to learn from patients who had raised complaints or concerns and also when patients had complemented the practice and the staff who worked there.

Management lead through learning and improvement

Staff we spoke with said the practice supported them to maintain their clinical professional development through training and mentoring. We saw that appraisals took place which included development plans for clinical staff. Staff told us that the practice was very supportive of training and development opportunities. GPs recorded learning activities for their appraisals.

The practice had completed thorough 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. There was evidence that feedback from significant events was supplied to other agencies to help improve learning. Staff we spoke with consistently referred to the open and honest culture within the practice and the leadership's desire to learn and improve outcomes for patients.

The practice reviewed their two week wait referrals for possible cancer retrospectively to see if they could take any learning from the outcomes. Bi monthly clinical update meetings reviewed QOF disease groups, protocols were checked and new guidelines discussed.

The practice manager met regularly with other practice managers in the area and shared learning and experiences from these meetings with colleagues. GPs met with colleagues at locality and CCG meetings. They also attended learning events and shared information from these with the other GPs in the practice.