Prudhoe Medical Group

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?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Good ●
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Prudhoe Medical Group on 16 October 2014 and visited the surgery in Prudhoe. We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

Overall, we rated the practice as outstanding, although there were some areas where the practice should make improvements. Our key findings were as follows:

- Patients reported good access to the practice and continuity of care, with urgent appointments available the same day.
- Patients said, and our observations confirmed, they were treated with kindness and respect.
- Patient outcomes were at or above average for the locality and good practice guidance was referenced and used routinely.
- The practice was visibly clean and tidy.
- The practice learned from incidents and took action to prevent a recurrence.

We saw the following areas of outstanding practice:

- The practice was considered to be outstanding in terms of their effectiveness. Staff were actively engaged in activities to monitor and improve quality and outcomes for patients.
- Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health.
- The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. Care plans had been developed for 160 patients (more than 2% of the practice's patient list size) and screening for early signs of dementia in patients had been introduced two years ago. This had identified an additional 19 patients, the majority of whom had later received a diagnosis of dementia.
- The practice had a rolling programme of clinical audit. The GPs showed us four examples of clinical audits that had been undertaken in the last year. Three of

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these were repeat audit cycles, where the practice was able to demonstrate the changes resulting since the initial audits had been carried out. Outcomes for patients had improved as a result.

- The practice demonstrated it was aware of the needs of its population. For example, the percentage of patients using long acting reversible contraceptives (LARCs) was higher than that being achieved by specialist family planning clinics. The GPs felt this contributed significantly to the practice having a termination of pregnancy rate for its patients of less than half the national average.
- The practice was considered to be outstanding in terms of being well-led. The leadership, governance and culture were used to drive and improve the delivery of high quality, person-centred care.
- There was an open culture within the practice and staff were actively encouraged to raise concerns and suggestions for improvement.
- The leadership were responsible for driving continuous improvement and staff were accountable for delivering change.

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

The practice should:

- Ensure staff who record the temperatures of fridges used to store vaccines are aware of the acceptable temperature range and know how to respond to recorded temperatures outside this range.
- Improve arrangements for the recording of blank prescription forms on receipt.

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

Are services effective?

Outstanding

The practice is rated as outstanding for effective. Our findings at inspection showed systems were in place to ensure that all clinicians were not only up-to-date with both good practice and other locally agreed guidelines, but we also saw evidence that confirmed these guidelines were influencing and improving practice and outcomes for their patients. We saw data that showed the practice is performing highly when compared to neighbouring practices in the Clinical Commissioning Group (CCG). The practice is using innovative and proactive methods to improve patient outcomes and it links with other local providers to share best practice.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the CCG to secure service improvements where these were identified. Patients reported good access to the practice, a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

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Are services well-led?

Outstanding 

The practice is rated as outstanding for well-led. The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients and had a very active patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Outstanding 

The practice is rated as outstanding for the care of older people. There were aspects of the practice which were outstanding and related to all population groups. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered personalised care to meet the needs of the older people in its population. For example, care plans had been developed for 160 patients (more than 2% of the practice's patient list size) and screening for early signs of dementia in patients had been introduced two years ago. The practice had written to patients over the age of 75 years to inform them who their named GP was. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Outstanding 

The practice is rated as outstanding for the population group of people with long term conditions. There were aspects of the practice which were outstanding and related to all population groups. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. Patients had reviews to check their health and medication needs were being met. The practice aimed to complete reviews for patients with more than one long term condition at the same appointment; reducing the need for patients to attend on multiple occasions. For those people with the most complex needs the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Outstanding 

The practice is rated as outstanding for the population group of families, children and young people. There were aspects of the practice which were outstanding and related to all population groups. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, the practice had processes in place to identify and support local families in these circumstances. Immunisation rates were relatively high for all standard childhood immunisations. For example, MMR vaccination rates for five year old children were 97.5% compared to an average of 96.5% in the local CCG area and Hib/Men C Booster rates for the same age group were 96.3% compared to an average locally of 91.3%. Patients told us that

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children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with examples of joint working with midwives and health visitors. The practice had a termination of pregnancy rate for its patients of less than half the national average.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the population group of the working-age people (including those recently retired and students). There were aspects of the practice which were outstanding and related to all population groups. The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the population group of people whose circumstances may make them vulnerable. There were aspects of the practice which were outstanding and related to all population groups. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out health checks for people with learning disabilities. The practice offered longer appointments for people, if required.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the population group of people experiencing poor mental health (including people with dementia). There were aspects of the practice which were outstanding and related to all population groups. Patients experiencing poor mental health had received an annual physical

Summary of findings

health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had care planning in place for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. Information and leaflets about services were made available to patients within the practice.

Summary of findings

What people who use the service say

All but one of the 15 patients we spoke with were complimentary about the services they received at the practice. They told us the staff who worked there were very helpful and friendly. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were generally happy with the appointments system.

We reviewed 25 CQC comment cards completed by patients prior to the inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided. Feedback on the length of time to obtain an appointment was also generally positive.

The latest National GP Patient Survey completed in 2013 showed patients were satisfied with the services the practice offered. The results were mainly in line with other GP practices nationally, and in some areas better. The results were:

- The proportion of respondents who would recommend their GP surgery– 85.2%;
- The proportion of respondents who stated that the last time they wanted to see or speak to a GP or nurse from their GP surgery, they were able to get an appointment – 96.2%;
- GP Patient Survey score for opening hours– 88.5%;
- The proportion of respondents who gave a positive answer to 'Generally, how easy is it to get through to someone at your GP surgery on the phone – 85.4%;
- Percentage of patients rating their experience of making an appointment as good or very good – 82.5%;
- The proportion of respondents who described the overall experience of their GP surgery as good or very good – 84.8%.

These results were based on 130 surveys that were returned from a total of 262 sent out; a response rate of 49.6%.

Areas for improvement

Action the service SHOULD take to improve

- The practice should ensure staff who record the temperatures of fridges used to store vaccines are aware of the acceptable temperature range and know how to respond to recorded temperatures outside this range.
- The practice should improve arrangements for the recording of blank prescription forms on receipt.

Outstanding practice

- The practice was considered to be outstanding in terms of their effectiveness. The practice was proactive in the management, monitoring and improving of outcomes for patients. For example GPs, in partnership with members of the practice's patient participation group (PPG), had gone out into the community to raise awareness of the risks associated with excessive consumption of alcohol.
- The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. Care plans had been developed for 160 patients (more than 2% of the practice's patient list size) and screening for early signs of dementia in patients had been introduced two years ago. This had identified an additional 19 patients, the majority of whom had later received a diagnosis of dementia.
- The practice had a rolling programme of clinical audit. The GPs showed us four examples of clinical audits that had been undertaken in the last year.

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Three of these were repeat audit cycles, where the practice was able to demonstrate the changes resulting since the initial audits had been carried out. Outcomes for patients had improved as a result.

- The practice demonstrated it was aware of the needs of its population. For example, the percentage of patients using long acting reversible contraceptives (LARCs) was higher than that being achieved by specialist family planning clinics. The GPs felt this contributed significantly to the practice having a termination of pregnancy rate for its patients of less than half the national average.
- The practice was considered to be outstanding in terms of being well-led. The leadership, governance and culture were used to drive and improve the delivery of high quality, person-centred care.
- There was an open culture within the practice and staff were actively encouraged to raise concerns and suggestions for improvement.
- The leadership were responsible for driving continuous improvement and staff were accountable for delivering change.

Prudhoe Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP and the team included a specialist advisor with experience of GP practice management and commissioning of primary care services.

Background to Prudhoe Medical Group

The practice is located in Prudhoe in Northumberland. The practice covers the area that extends northwards from Prudhoe to the A69, west to the A68 and up to the county borders with Tyne and Wear and County Durham. The practice provides services from the following address and we visited here during this inspection:

Kepwell Bank Top, Prudhoe, Northumberland NE42 5PW.

The practice is based at ground floor level. It offers on-site parking including a disabled parking bay, a WC and step-free access. The practice provides services to just fewer than 6,700 patients of all ages based on a Personal Medical Services (PMS) contract agreement for general practice.

The practice has four GP partners and a salaried GP (two male GPs, three female GPs overall), three practice nurses, one health care assistant, a practice manager and 10 secretarial, administrative and reception staff.

The service for patients requiring urgent medical attention out-of-hours is provided by Northern Doctors.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care

Detailed findings

- People experiencing poor mental health

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. This did not highlight any significant areas of risk across the five key question areas. As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local Clinical Commissioning Group (CCG).

We carried out an announced visit on 16 October 2014. The inspection team spent seven hours inspecting the service at the practice's surgery in Prudhoe. We spoke with 15 patients and 11 members of staff from the practice. We spoke with and interviewed the practice manager, four GPs, a GP registrar (a GP still in training), a practice nurse, three administration and reception staff and a domestic cleaner. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 25 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, we did not identify any safety concerns that related to how this practice operated. Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards reflected this.

As part of our planning we looked at a range of information available about the practice. This included information from the General Practice High Level Indicators (GPHLI) tool, the General Practice Outcome Standards (GPOS) and the Quality Outcomes Framework (QOF). The latest information available to us indicated there were no areas of concern in relation to patient safety.

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to 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, a recent incident had been recorded where a patient with a similar name had been booked in for an appointment in error. On investigation, it was identified that two patients had similar names and when the appointment was booked, the patient's dates of birth had not been checked. This had resulted in a change of practice to ensure dates of birth were always checked when booking appointments. Our observations during the inspection showed this had been put into practice.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We asked for and saw records were kept of significant events that had occurred during the last two years, and these were made available to us. Significant events were discussed at the practice's monthly clinical and fortnightly staff meetings and a dedicated meeting occurred every two or three months to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who managed and monitored them. We looked at eight incidents recorded to date in 2014 and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, actions to be taken when patients changed their repeat medicines, including contraceptive pills, had been discussed in a practice meeting.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all were aware of any relevant to the practice 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 all staff had received, or were booked to receive, 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. Contact details were easily accessible.

The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children who had been trained to level three to enable them to fulfil this role. Staff we spoke with were aware of who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so

staff were aware of any relevant issues when patients attended appointments. For example, patients who had been subjected to, or were deemed to be at risk of domestic violence, were flagged on the system.

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

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

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. On the day of the inspection the practice was running an open access flu clinic. The main fridge was in the main treatment room which was unlocked because of the frequent need to have access. We were told this was not normal practice, however staff were present in this area for the majority of the time therefore any risk was minimal. There was a policy for checking medicines were kept at the required temperatures. This was being followed by the practice staff; however it appeared no interpretation of the recorded temperatures was being made. The practice had a second fridge located in a meeting room. Temperatures were recorded on a daily basis, however records showed the temperature had been recorded outside the 'accepted range' of two to eight degrees Celsius for about two weeks. No action had been taken in response to this. We saw there was a discrepancy between the fridge's internal temperature gauge and the independent thermometer used. The fridge's own temperature record was within the acceptable range, while the independent thermometer recorded too high a temperature. One of the nursing staff immediately checked the temperature of the fridge using another thermometer and found there was a fault with the original independent thermometer. The result of this was the medicines in the fridge were deemed 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. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of the actions taken in response to reviews of prescribing data. For example, patterns of antibiotic and hypnotics and prescribing within the practice compared well to other practices in the area. The practice had also identified the prescribing of laxatives as an area to review, as the data suggested it was prescribing more than other practices in the area.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. GPs we spoke with told us how the practice had improved its arrangements for issuing prescriptions for controlled drugs (medicines that require extra checks because of their potential for misuse). They described a robust system to us which prevented the issue of prescriptions for these medicines before they were due. We saw records of blank prescription form serial numbers were made when the forms were issued to GPs; however records of serial numbers were not recorded on receipt into the practice. This is not in line with best practice guidance issued by NHS Protect.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept, including audits of the quality of domestic cleaning. We viewed a sample of these audits and saw improvements had been achieved. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had recently taken on this role. They told us they had not completed any further training to enable them to provide advice to the practice on infection control or carry out staff training; however they would like to do so. We spoke with the practice manager and GP partners about this and they said they would look to support this. All staff received induction training about infection control specific to their

role and thereafter annual updates were provided internally. We saw evidence of infection control audit activity, the most recent of which was completed in May 2014 by the practice manager. We saw that actions identified had been completed, for example, improved clinical waste signage in clinical rooms.

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

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

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

Equipment

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

Staffing & Recruitment

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

Staff told us about the arrangements for planning and monitoring the number of staff 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 were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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

Monitoring Safety & Responding to Risk

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

We saw that any identified risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager told us a comprehensive review of risks was completed on a monthly basis. We saw records confirming the latest review had been completed in September 2014. We saw a record of actions required and taken was maintained.

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

Arrangements to deal with emergencies and major incidents

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

Emergency medicines were available in a secure area of the practice and all staff knew of their location. A resuscitation trolley was located in the main treatment room. There was

Good

Are services safe?

a good selection of paediatric and adult masks and airways. Intravenous cannulation was available with a variety of venflons (a small tube that can be inserted into a body cavity, duct, or vessel) and all were in date. There was a laminated sheet that clearly listed the contents of the trolley and this corresponded to the medicines available. The defibrillator and oxygen were accessible and records of weekly checks of the defibrillator were up to date. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather and access to the building. The practice manager and one of the GP partners led on this area.

Outstanding ☆

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 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, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, we were told that patients with long term conditions such as diabetes were invited into the practice to have their medication reviewed for effectiveness.

The GPs told us they led in specialist clinical areas such as diabetes, obesity and contraception. Practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. Staff had access to the necessary equipment and were skilled in its use; for example, blood pressure monitoring equipment and an electrocardiogram (ECG) machine.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. GPs spoke about how proud they were of work the practice had completed to identify and support patients with dementia type illnesses. Care plans had been developed for 160 patients (more than 2% of the practice's patient list size) and screening for early signs of dementia in patients had been introduced two years ago. This had identified an additional 19 patients, the majority of whom had later received a diagnosis of dementia.

The senior GP partner showed us data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing which was favourable to similar practices.

The practice had low referral rates to secondary and other community care services for all conditions compared to other practices in the area. All GPs we spoke with said this was as a direct result of them meeting on a weekly basis to discuss individual cases before a referral was made. Referral activity was fed back to the practice four times a year by the local CCG.

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

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

Management, monitoring and improving outcomes for people

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

The practice had a rolling programme of clinical audit. The GPs showed us four examples of clinical audits that had been undertaken in the last year. Three of these were 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 responded to a significant event in 2008 by auditing the overuse of salbutamol and terbutaline inhalers by patients with asthma. This had been identified as a contributing factor to the significant event. The initial audit identified 51 patients classed as high users (receiving more than 12 inhalers per year) and therefore potentially at risk, with 21 of these using an average of more than two inhalers per month. The latest audit results showed this number had decreased to 19 patients, with no patients identified as using an average of more than two inhalers per month. Of the 19 patients, only two had received over 20 inhalers per year. The GPs we spoke with were proud of what the practice had achieved in this area. They said it was an example of how staff, clinical and non-clinical, had worked together to improve the safety and quality of lives for their patients.

The practice was proactive in the management, monitoring and improving of outcomes for patients. A number of examples were provided by the GPs we spoke with to support this. For example GPs, in partnership with members of the practice's patient participation group (PPG), had gone out into the community to raise awareness

of the risks associated with excessive consumption of alcohol. GPs had also discussed the importance of embedding discussions around alcohol consumption within their consultations with patients. They also fronted a local campaign in the media on this subject.

Another example given was work the practice had completed on effective contraception. The percentage of patients using long acting reversible contraceptives (LARCs) was higher than that being achieved by specialist family planning clinics. The GPs felt this contributed significantly to the practice having a termination of pregnancy rate for its patients of less than half the national average. The GPs felt this showed the practice were highly effective with regards to contraception; helping to keep their patients safe and avoiding unwanted pregnancies.

The practice also 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 practice had achieved 99.7% of the points available for clinical results, which included all of the points available for cardiovascular disease primary prevention. This practice was not an outlier for any QOF (or other national) clinical targets.

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

The practice also participated in local benchmarking. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes comparable or favourable to other services in the area. For example, the practice compared favourably to others in the area on the prescribing of hypnotics.

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 with the General Medical Council).

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

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, we found they were trained to administer vaccines. Nurses were responsible for the review of patients with long-term conditions such as asthma and were trained to fulfil this role.

We saw the practice had an induction programme to be used when staff joined the practice. This covered individual areas of responsibility and had been introduced recently but not used fully due to low turnover rates of staff. A pack had also been developed to support locum GPs and GP registrars (trainee GPs) with their work.

The administrative and support staff had clearly defined roles, however they were also able to cover tasks for their colleagues due to a programme of multi-skilling that was in place. 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 people's needs and manage complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service, were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who reviewed these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

GPs told us they worked well together as a team. An example of this was the regular checking of each other's test results, including blood test results. Agreements were in place that meant only one GP would take annual leave at any given time. The remaining GPs provided cover for their timetabled sessions.

The practice held multidisciplinary team meetings twice a month to discuss the needs of high risk patients, for example, those with end of life care needs. These meetings were attended by district nurses, social workers and palliative care nurses, and decisions about care planning were documented in a shared care record. All of the practice's GPs attended these meetings and used a traffic light system for risks associated with patients. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice was a member of a group of GP practices located in the West of Northumberland who met regularly to build relationships and share learning with the aim of improving patient care. The practice team felt this had been beneficial for both themselves and their patients. For example, practice-based warfarin monitoring had been introduced through the work of this group.

Information Sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times.

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 delivered internally on the subject by one of the GP partners. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. Clinical staff we spoke with 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 the fitting of contraceptive implants and 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. We saw an example where a best interests decision had been documented in a patient's electronic records. The patient had learning disabilities and early dementia with life limiting conditions. There was good evidence of multidisciplinary team (MDT) and family involvement, and records of a consensually agreed best interests decision being made and clearly recorded.

Health Promotion & Prevention

The practice offered all new patients a consultation. Clinicians completed the 'new patient assessment' which involved explaining the service to the patient, reviewing their notes and medical history, and the recording of basic information about the patient. For example, confirming any medicines they were currently taking. The patient's needs were assessed and where appropriate, they were placed into the relevant monitoring service. For example, children would be placed within the immunisation programme at the appropriate point.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the Clinical Commissioning Group (CCG). For example, MMR vaccination rates for five year old children were 97.5% compared to an average of 96.5% in the local CCG area and Hib/Men C Booster rates for the same age group were 96.3% compared to an average locally of 91.3%.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

We found patients with long term conditions were recalled to check on their health and review their medications for effectiveness. The practice's electronic system was used to flag when patients were due for review. This 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. The practice had recently introduced a system whereby patients with more than one long term condition would have their reviews aligned to one appointment with the practice nurse. It was hoped this would remove the need for patients whose conditions were being stably managed to attend more than once. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening.

Medicine reviews were done in the presence of the patient. Some of the patients we spoke with told us they were on regular medicines. They confirmed they were asked to attend the practice to review their conditions and the effectiveness of their medicines.

There was a range of information on display within the practice reception area. This included a number of health promotion and prevention leaflets, for example, on smoking cessation and alcohol consumption. A registered healthcare charity had been given the opportunity to put on a display within the practice.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

All but one of the 15 patients we spoke with said they were treated with respect and dignity by the practice staff at all times. Comments left by patients on CQC comment cards reflected this. Of the 25 CQC comment cards completed, 15 patients made direct reference to the caring manner of the practice staff. Words used to describe the approach of staff included professional, helpful, friendly, polite, supportive, obliging, caring and respectful. None of the CQC comment cards completed raised any concerns in this area.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate, understanding and caring, while remaining respectful and professional. The practice was running an open access flu clinic for all eligible patients on the day of our inspection. The patient waiting area was very busy; however the GPs and nursing staff came to collect patients for their vaccinations in person. This was clearly appreciated by the patients who attended the practice.

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

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. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation.

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 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 80% of practice respondents said the GP was good at involving them in care decisions and 81% felt the GP was good at explaining treatment and results. Both these results were in line with the CCG area and national averages.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and supported these views.

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

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice and rated it well in this area. The CQC comment cards we received were also consistent with this feedback. For example, patients commented the GPs and staff knew them well and were caring, reassuring and supportive. Patients also commented they felt staff regularly 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.

Support was provided to patients during times of bereavement. Families were offered a visit from a GP at these times for support and guidance. Staff were kept aware of patients who had been bereaved so they were

Good

Are services caring?

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 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 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 people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice used a traffic light system based risk tool, which helped doctors detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple health conditions.

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. We saw where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, the introduction of a localised INR (international normalised ratio) monitoring service. INR is a measurement of how long it takes blood to form a clot. It is used to determine the effects of oral anticoagulants such as warfarin on the clotting system.

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. There had been very little turnover of staff in recent years which enabled good continuity of care and accessibility to appointments with a GP or nurse of choice. For example, patients could access appointments face-to-face in the practice, receive a telephone call back from a clinician or be visited at home. 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.

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 and late appointments each week. This helped to improve access for those patients who worked full time. The practice also had access to telephone translation services if required, for those patients whose first language was not English.

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

The practice provided staff with equality and diversity training. Staff we spoke with confirmed that they had completed the training and that equality and diversity was regularly discussed at staff meetings.

Access to the service

Patients we spoke with and those who filled out CQC comment cards all said they were satisfied with the appointment systems operated by the practice. They said they could see a doctor on the same day if they needed to and could see another doctor if there was a wait to see the doctor of their choice. This was reflected in the results of the most recent national GP Patient Survey (2013/14). This showed 91% of patients who responded were able to get an appointment to see or speak to someone the last time they tried and 99% said the last appointment they received was convenient. These results were based on the responses of 130 patients and were above the weighted CCG (local area) averages.

Appointments were available from 7.30am to 7.00pm on weekdays. 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. Practice staff we spoke with told us appointments were kept for urgent matters at the end of the morning and afternoon surgeries. We looked at the practice's electronic appointments booking system, which confirmed this. Patients we spoke with told us they had been able to access these appointments at times of urgent need.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Information was available to patients about appointments on the practice website. This included how to arrange appointments and home visits and how to book appointments through the website. Consultations were provided face-to-face at the practice, over the telephone, or by means of a home visit by the GP. This helped to ensure people had access to the right care at the right time.

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

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

We saw that some of the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

Listening and learning from concerns & complaints

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

We saw the practice had received six formal complaints during 2013/14 and these had been reviewed as part of the practice's formal annual review of complaints. Where mistakes had been made, it was noted the practice had apologised formally to patients and taken action to ensure they were not repeated. Complaints and lessons to be learned from them were discussed at staff meetings.

Staff we spoke with were aware of the practice's policy and knew how to respond in the event of a patient raising a complaint or concern with them directly. We saw the practice had a 'suggestion box' in place for patients to use.

Only one of the 15 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 25 CQC comment cards completed by patients indicated they had felt the need to complain.

The practice had responded to concerns raised and feedback provided by patients regarding the telephone system it used. The practice had used a 0844 number previously based on a contractual agreement they had entered into some years ago, but now had a local phone number again. The practice had taken the decision to 'buy itself out' of this contract at its own cost. We were told patient feeling had been strong, so despite the cost involved they had decided to get out of the contract. We spoke with some patients about this and the change had been well received.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found leaders had a shared purpose and strived to deliver and motivate staff to succeed. The practice's statement of purpose said its aims and objectives included the "Provision of good quality primary care services", "Proactive management of long-term conditions, from birth through to the end of life" and the practice would "liaise with other agencies and NHS colleagues in an effective manner with the focus on what is best for the patient." It was evident in discussions we had with staff throughout the day that this was a shared vision and was fully embedded.

There was strong working ethic of collaboration and support across the staff team and a common focus on improving the quality of care and patients experiences. We spoke with 11 members of staff and without exception they all knew the provision of high quality care for patients was the practice's main priority. They also knew what their responsibilities were in relation to this and how they played their part in delivering this for patients.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared drive on any computer within the practice. We looked at a sample of these policies and procedures and saw most staff had accessed and read them. The practice manager showed us how they were able to audit to check that staff had accessed the practice's policies online. All of the policies and procedures we looked at had been reviewed regularly and were up-to-date.

The practice held regular governance meetings where matters such as performance, quality and risks were discussed. For example, the practice used the Quality and Outcomes Framework (QOF) as an aid to measure their performance. The QOF data for this practice showed it was performing above the averages of the local Clinical Commissioning Group (CCG) and across England as a whole. Performance in these areas was monitored by the practice manager and GPs, supported by the administrative staff. We saw that QOF data was discussed at team meetings and action plans were produced to maintain or improve outcomes. For example, the practice had attempted to contact patients who had been classed as part of the practice's 'clinical exception rate'. Patients can be exception-reported from individual indicators for various reasons, for example, if they were newly diagnosed or newly registered with a practice, if they did not attend appointments or where the treatment was judged to be inappropriate by the GP (such as medication cannot be prescribed due to side-effects). By following up these exception reported patients, the practice had attempted to ensure all patients had the opportunity to receive the best outcomes and reduced risks to their health and wellbeing.

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

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

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

The practice manager and GPs told us forward planning was discussed regularly among all staff, although this hadn't been formally documented in one place. The practice manager spoke of a number of individual plans for improvement, for example, on medicines management, and said it was their intention to bring them all together into a strategic plan. The GP partners met on a monthly basis to discuss business related matters. There was an appreciation of the need to change, for example, to work more closely with local practices in the future. One of the GPs we spoke with told us this work had already started and discussions with local practices were ongoing.

Are services well-led?

Outstanding ☆

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

Leadership, openness and transparency

The practice had a clear leadership structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner was the lead for health and safety and contraception. We spoke with 11 members of staff and they were all clear about their own roles and responsibilities. We found there were high levels of staff satisfaction. Every member of staff we spoke with was openly proud of the organisation as a place to work and spoke highly of the open and honest culture. There were consistently high levels of staff engagement.

We saw from minutes that staff meetings were held regularly. Staff told us that there was an open culture within the practice and they were actively encouraged to raise concerns and suggestions for improvement.

We found the practice leadership proactively drove continuous improvement and staff were accountable for delivering this. There was a clear and proactive approach to seeking out and embedding new ways of providing care and treatment. Examples included work completed on alcohol awareness, family protection and contraception.

GPs we spoke with said staff performance was managed with an open approach based upon appraisals, performance plans and regular reviews. They told us the practice had a 'high performing' team and none of the staff employed were underperforming. They felt the open culture supported frankness when any occasional dips in standards were experienced, and these were short-lived. All of the staff we spoke with said they enjoyed working as part of a high performing team and were open to constructive challenge.

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

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

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions on a daily basis. Staff we spoke with told us they regularly attended staff meetings. 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 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. In the past the group had conducted a survey of younger patients in an attempt to try and engage with them. The PPG met every quarter and a representative from the practice always attended to support the group. We saw the results of the latest survey the group had overseen on drug compliance. Although there were no actions that came from the survey, it highlighted a lack of awareness among patients on the amount of drug wastage in the NHS. The results and analysis from surveys were available on the practice website. We spoke with some members of the group 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 asked members of the group to support them with their work on alcohol awareness in the community. A member of the group had manned a display stand with one of the GPs in a local sports centre. The practice had also helped the patient group to secure funding to buy some books on healthcare. The books were placed in the local library for the community to access and patients were known to have regularly accessed these.

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

Management lead through learning & improvement

The practice was a GP training practice and we spoke with a GP registrar (trainee GP) who had recently joined the

Are services well-led?

Outstanding ☆

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

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 the other GPs and clinical staff at the practice.

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

The practice was a member of a group of GP practices located in the West of Northumberland who met regularly to build relationships and share learning with the aim of improving patient care. The practice team felt this had been beneficial for both themselves and their patients. For example, practice-based warfarin monitoring had been introduced through the work of this group.

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

The practice was highly proactive with regards to improving the quality of services it provided. For example, screening for early signs of dementia in patients had been introduced by the practice two years ago; well ahead of the introduction of the enhanced service. This had identified an additional 19 patients, the majority of whom had later received a diagnosis of dementia. The early identification of this by the practice resulted in improvements to the quality of services these patients received. This proactive approach meant the practice had missed out on the additional funding by delivering the enhanced service ahead of time; however the GPs we spoke with said their reward had been the improvements to patient care achieved. This typified the proactive and forward thinking approach adopted by all of the staff in the practice.

Another example given was work the practice had completed on effective contraception. The percentage of patients using long acting reversible contraceptives (LARCs) was higher than that being achieved by specialist family planning clinics. The GPs felt this contributed significantly to the practice having a termination of pregnancy rate for its patients of less than half the national average. The GPs felt this showed the practice were highly effective with regards to contraception; helping to keep their patients safe and reducing the numbers of unwanted pregnancies.

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. The practice had a rolling programme of clinical education meetings. For example, a GP had attended a course run by the Royal College of GPs and had shared their learning with their peers. This had resulted in GPs introducing discussions around alcohol awareness into their consultations with patients as a matter of routine. This had led to improvements in the identification of patients at risk from high levels of alcohol consumption that could be perceived locally as normal.

Information and learning was shared verbally between staff and the practice also used a 'learning noticeboard' on the practice's computer network where staff could access information and learning at any time. Use of the 'noticeboard' was monitored to provide assurance that staff made effective use of the learning opportunities available to them.