The Grove 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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Grove Medical Group on 3 March 2015. Overall, the practice is rated as Good. Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. They were also good for providing services for the six key population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Information about safety was appropriately recorded and reviewed;
- Risks to patients were assessed and well managed;
- The practice was clean, hygienic and good infection control arrangements were in place;
- Patients' needs were assessed and care and treatment was planned and delivered in line with current legislation.
- Patients said they were treated with compassion, dignity and respect and that they were involved in decisions about their care and treatment;
- Information about the services provided and how to raise any concerns or complaints, was accessible and easy to understand;
- Patients said they found it easy to make an appointment and urgent same-day access was available;
- Three patients provided feedback within the CQC comment cards about the difficulty in accessing the practice if you used a wheelchair. The practice was in progress of making plans to address these concerns. Otherwise the practice had good facilities and was well equipped to treat patients and meet their needs;
- There was a clear leadership structure and staff felt supported by management. The practice actively sought feedback from patients.
- The practice had been visited by a team from Skills for People to learn how they could improve the way they met the needs of patients with learning disabilities. They had acted upon the recommendations made.

Summary of findings

We saw an area of outstanding practice:

- For the last three years the practice had ran an annual workshop for young people to encourage emotional and physical well-being. Its aim was to improve self-esteem and confidence. The practice presented this at a Royal College of General Practitioners (RCGP) conference as an exemplar of health promotion.

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

The provider should:

- review their approach to checking on the suitability of staff undertaking the chaperone role within the practice. The practice should consider obtaining police record checks through the Disclosure and Barring Service (DBS) for those staff that may be required to act as a chaperone for vulnerable patients or undertaking risk assessments for those who act as chaperones, but do not require a criminal records check because of the safeguards already in place.
- ensure patients with physical disabilities are supported to have equitable access to the service, by means of reasonable adjustments made by the practice to the facilities.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care excellence and used it routinely. Patients' needs were assessed and care and treatment was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

The practice had systems in place for completing clinical audit cycles to review and improve patient care. Staff had received training appropriate to their roles and any further training had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams. Discrimination was avoided when making care and treatment decisions.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a

Summary of findings

named GP and that there was continuity of care, with urgent appointments available the same day. Three patients provided feedback within the CQC comment cards about the difficulty in accessing the practice if you used a wheelchair. The practice was in process of making plans to address these concerns.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. They were responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

For patients on the palliative care register and for the most elderly and frail patients the practice supported them by offering access, with a response within 24 hours, to a GP via the phone when required. Age UK visited the practice weekly to deliver a clinic offering advice and support for older people.

People with long term conditions

Good

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

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

For the last three years the practice had ran an annual workshop for young people to encourage emotional and physical well-being. Its aim was to improve self-esteem and confidence.

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Working age people (including those recently retired and students)

Good

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

Three patients provided feedback within the CQC comment cards about the difficulty in accessing the practice if you used a wheelchair. The practice was in progress of making plans to address these concerns.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. They carried out annual health checks for people with a learning disability. They offered longer appointments for those who required them. The practice had been visited by a team from Skills for People to learn how they could improve the way they met the needs of patients with learning disabilities. They had acted upon the recommendations made.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people with poor mental health (including patients with dementia). The practice held a register of patients experiencing poor mental health and there was evidence they carried out annual health checks for these patients. The practice regularly worked with the multi-disciplinary teams in case management of people experiencing poor mental health, including those with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary

organisations including MIND and SANE. They had systems in place to follow up patients who had attended Accident and Emergency (A&E). Staff had received training on how to care for people with dementia.

Summary of findings

What people who use the service say

We spoke with eight patients during the inspection. This included three patients from the practice Patient Participation Group (PPG).

Patients told us staff were friendly, and treated them with dignity and respect. Also, when they saw clinical staff, they felt they had enough time to discuss the reason for their visit and staff explained things to them clearly in a way they could understand. Patients told us they could get an appointment easily, and this was always quickly if there was an urgent need.

The patients we spoke with told us they would recommend the practice to family and friends.

We reviewed 78 CQC comment cards completed by patients prior to the inspection. The majority of these commented positively on the practice, staff and the care and treatment offered. In particular patients commented the practice was clean and tidy; that staff were caring and professional; and they can normally get an appointment quickly when they need one. Words used to describe the practice included, ten out of ten; exceptional, outstanding, excellent and very good.

Seven comment cards included negative feedback about the practice. Three stated the practice was not easily accessible if you use a wheel chair, particularly; the front entrance ramp was too steep for patients in a wheel chair to use independently.

Other negative comments related to poor communication by practice staff and complaints about the practice telephone system.

The latest GP Patient Survey published in 2015 showed the majority of patients were satisfied with the services the practice offered. The majority of patients who responded described their overall experience as good. (97.4% compared to a national average of 85.7%.)

The three responses to questions where the practice performed the best when compared to other local practices were:

- 89% of respondents usually wait 15 minutes or less after their appointment time to be seenLocal (CCG) average: 70%
- 93% of respondents described their experience of making an appointment as goodLocal (CCG) average: 78%
- 96% of respondents were able to get an appointment to see or speak to someone the last time they triedLocal (CCG) average: 85%

The three responses to questions where the practice performed least well when compared to other local practices were:

- 86% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their careLocal (CCG) average: 88%
- 90% of respondents said the last GP they saw or spoke to was good at explaining tests and treatmentsLocal (CCG) average: 90%
- 95% of respondents said the last GP they saw or spoke to was good at listening to themLocal (CCG) average: 94%

These results were based on 115 surveys that were returned from a total of 257 sent out; a response rate of 45%.

Areas for improvement

Action the service SHOULD take to improve

- The practice should review their approach to checking on the suitability of staff undertaking the chaperone role within the practice. The practice should consider obtaining police record checks through the Disclosure and Barring Service (DBS) for those staff that may be required to act as a chaperone for vulnerable patients or undertaking risk assessments for those who act as chaperones, but do not require a criminal records check because of the safeguards already in place.

Summary of findings

- The practice should ensure patients with physical disabilities are supported to have good access to the service, by means of reasonable adjustments made by the practice to the facilities.

Outstanding practice

- For the last three years the practice had ran an annual workshop for young people to encourage emotional and physical well-being. Its aim was to improve self-esteem and confidence. The practice presented this at a Royal College of General Practitioners (RCGP) conference as an exemplar of health promotion.

The Grove Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

a **CQC Lead Inspector.** The team included a GP, a specialist adviser with a background in practice management and a CQC integrated care manager.

Background to The Grove Medical Group

The Grove Medical Group practice is located just off Gosforth High Street, in the Gosforth area of Newcastle Upon Tyne. The practice provides services to around 12,700 patients. The practice delivers services from The Grove Medical Group, 1 The Grove, Gosforth, Newcastle Upon Tyne, Tyne and Wear, NE3 1NU.

The practice is situated in a building which has been converted for use as a GP practice. Patient facilities are on the ground and first floors. Some of the consultation rooms within the practice are reached by using steps. This makes them inaccessible to patients who have poor mobility or those who use mobility aids, such as wheelchairs. The practice can arrange for patients to be seen in a ground floor room with no step access for those who require it. There is a disabled WC. There is a small car park in the grounds of the practice and nearby parking on the street.

The practice has eight GP partners, one salaried GP, three GP Registrars, four practice nurses, a healthcare assistant, a practice manager and staff who carry out reception and administrative duties. There are both male and female clinicians at the practice.

Surgery opening times are Monday and Tuesday 8:00am to 8:00pm, Wednesday, Thursday and Friday 8:00am to 6:30pm.

The practice provides services to patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

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

The practice population age distribution follows a similar pattern to the national average, with the majority of patients within the 25 to 70 age range. The average male life expectancy is 77.8 years and the average female life expectancy is 81.4. The number of patients reporting with a long-standing health condition is similar to the national average (practice population 54.7% compared to a national average of 54%). The number of patients with health-related problems in daily life is also similar to the national average (49.9% compared to 48.9% nationally). There are a higher number of patients with caring responsibilities at 21.5% compared to 18.5% nationally.

Why we carried out this inspection

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

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

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 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 3 March 2015. We spoke with six patients' and14 members of staff. We spoke with five partner GPs, a salaried GP, a registrar doctor, the practice manager, three members of the nursing team, a healthcare assistant and three reception and administration staff. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 78 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.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the Care Quality Commission (CQC) at that time.

Good

Are services safe?

Our findings

Safe track record

We reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice. There were no notifications of safeguarding or whistleblowing concerns made to CQC.

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, they considered reported incidents, national patient safety alerts as well as comments and complaints received from patients.

Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, the practice had reviewed their approach to completion of paperwork relating to adoption following the identification of a significant event.

We reviewed safety records and incident reports for the last 12 months. We saw the practice had recorded eight such events. This showed the practice had managed these consistently over time and could show evidence of a safe track record over the long-term.

Learning and improvement from safety incidents

The practice was open and transparent when there were near misses or when things went wrong. The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to view these. Significant events were a standing item on clinical meeting agendas.

We saw evidence that significant events were also discussed at an annual dedicated 'time in' meetings to review actions from past significant events and complaints. We saw the notes of the last meetings which confirmed this. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration as a significant event or incident and they felt encouraged to do so. Staff told us they felt confident in raising issues to be considered at the meetings and felt action would be taken. A culture of openness operated throughout the practice, which encouraged errors and 'near misses' to be reported. Although the practice considered near misses as part of clinical meetings, they did not develop these into significant event analyses and did not record them as part of this process. Considering near misses as significant events would allow the practice to identify where processes are working well so they could ensure this continued.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We tracked two incidents and saw records were completed in a comprehensive and timely manner. Where follow up action was identified, we saw that accountabilities were identified and a priority and timescale given.

Where incidents and events meet threshold criteria, these were also added to the local CCG Safeguard Incident & Risk Management System (SIRMS). This allowed the practice to contribute to, and benefit from, learning identified from incidents across the local area and also to share information where more than one organisation was involved.

We saw evidence of action taken as a result of significant events. For example, the practice manager told us the way post-operative injections were arranged as a result of a significant event. This included making clear that GPs were responsible for scheduling these.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were added to the practice meeting agenda, where appropriate, to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received role specific training on safeguarding. We saw evidence that GPs had received the higher level of training for safeguarding children (Level 3). 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 and knew how to share

information, record safeguarding concerns and contact the relevant agencies in working hours and out-of-normal hours. Contact details were easily accessible on the practice intranet.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to within 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 to make staff aware of any relevant issues when patients attended appointments; for example, children subject to child protection plans or looked after children. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed.

The practice also had systems to monitor babies and children who failed to attend for health checks, childhood immunisations, or who had high levels of attendances at accident and emergency departments (A&E).

There was a chaperone policy, which was available on the staff intranet page. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). We saw this was also advertised in the waiting room and consulting rooms. A range of staff acted as chaperones, including nurses and reception staff. Receptionists had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. However, non-clinical staff who undertook chaperoning duties had not been subject to a police records check, known as a Disclosure and Barring Service (DBS) check. All staff who act as a chaperone should be subject to a DBS check or have a risk assessment in place to demonstrate why a DBS check is not required, to ensure patients are not put at unnecessary risk.

Medicines management

Arrangements were in place to regularly monitor the GPs' prescribing practice. A pharmacist from the Prescribing Support Unit attended the practice for one session per week. The GP we spoke with told us the pharmacist carried out various audits, which we saw evidence of, to make sure medicines were being used effectively. They also provided the practice with advice and support.

The practice had a supply of emergency drugs. These were stored out of view, but were not in a secure or staff controlled area. They included, for example, medicines for the treatment of a life-threatening allergic reaction and emergency oxygen. Arrangements were in place for emergency medicines to be checked regularly to make sure they were within their expiry date and suitable for use. All the medicines we checked were in date.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Patients were able to order repeat prescriptions using a variety of ways such as by telephone, online and by post. The practice website provided patients with helpful advice about ordering repeat prescriptions. Staff knew the processes they needed to follow in relation to the authorisation and review of repeat prescriptions. We observed reception staff dealing effectively with requests for repeat prescriptions.

A system was in place which helped to ensure patients who were receiving prescribed medicines were regularly reviewed. The GP we spoke with told us these reviews were carried out at least annually.

Members of the nursing staff were qualified as independent prescribers. We saw evidence they received regular supervision and support in their role. As well as updates in the specific clinical areas of expertise for which they prescribed.

Good

Are services safe?

Vaccines were administered by practice nurses using directions that had been produced in line with legal requirements and national guidance. We saw copies of directions that were signed by the nurse who used them.

Blank prescription forms were handled in accordance with national guidance and were kept securely, as were those awaiting issue. All prescriptions were reviewed and signed by a GP before they were given to the patient.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and procedures were in place and they covered a range of key areas such as, obtaining specimens. These provided staff with guidance about the standards of hygiene they were expected to follow and enabled them to plan and implement measures to control infection. The policy had recently been reviewed. A comprehensive infection control risk assessment and audit had recently been completed in order to identify any shortfalls or areas of poor practice. A detailed action plan, with timescales for completion, had been prepared to address the shortfalls identified.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We saw a number of patients hand in specimens to reception staff to send away for testing. We observed this was done in a way to minimise the risk of infection. Gloves were available to staff to use in handling specimens.

The clinical rooms we visited contained personal protective equipment such as latex gloves, and there were paper covers and privacy screens for the consultation couches. Arrangements had been made for the privacy screens to be regularly changed or cleaned. Spillage kits were available to enable staff to deal safely with any spills of bodily fluids. Written instructions were in place informing staff how to do this. Sharps bins were available in each treatment room to enable clinicians to safely dispose of needles. The bins had been appropriately labelled, dated and initialled. The treatment rooms also contained hand washing sinks, antiseptic gel and hand towel dispensers to enable clinicians to follow good hand hygiene practice.

Arrangements had been made to ensure the safe handling of specimens and clinical waste. For example, the practice had a protocol for the management of clinical waste and a contract was in place for its safe disposal. All waste bins were visibly clean and in good working order. A legionella risk assessment had been carried out in 2015. The practice was in progress of implementing the recommended checks and tests as a result of this. We did not identify any concerns regarding the arrangements to prevent legionella. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal).

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. The equipment was regularly inspected and serviced. We saw records confirming, where appropriate, the calibration of equipment had been regularly carried out.

Practice staff monitored the safety of the building to ensure patients were not put at risk. Regular checks of fire equipment had taken place. For example, an up-to-date fire risk assessment was in place. Weekly fire alarm tests were carried out by staff. The practice had an evacuation plan which informed staff how the building should be evacuated in the event of an emergency. The last recorded fire drill had taken place in November 2014. We checked the building and found it to be safe and hazard free. None of the patients we spoke to had any concerns about their safety when visiting the practice.

Staffing and 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 through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards they followed when recruiting clinical staff and non–clinical staff.

Good

Are services safe?

The recruitment policy stated that all staff would need to provide proof of a DBS check. However the practice manager told us that non-clinical staff had not been asked to undergo this check. The practice did not have in place a clear rationale as to which non-clinical staff needed to be subject to a DBS check. There was no evidence the practice had considered the need for this additional safety check prior to non-clinical staff undertaking chaperone duties.

The practice manager routinely checked the professional registration status of GPs and nurses (for GPs this is the General Medical Council (GMC) and for nurses this is the Nursing and Midwifery Council (NMC)) each year to make sure they were still deemed fit to practice. We saw records which confirmed these checks had been carried out.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying on the regulated activities. Staff told us there were effective arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff we spoke with were flexible in the tasks they carried out. This demonstrated they were able to respond to areas in the practice that were particularly busy. For example, within the reception on the front desk receiving patients or on the telephones.

Staff told us there were usually enough staff to maintain the smooth running of the practice and keep patients safe.

Monitoring safety and responding to risk

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and medical emergencies.

For example, a risk assessment screening tool had been used to identify patients at risk of an unplanned admission to hospital. Steps were being taken to complete emergency care plans to help prevent older patients and patients with long-term conditions experience unnecessary admissions into hospital. Information about patients with palliative care needs had been entered onto an electronic system which provided emergency professionals and out-of-hours clinical staff with access to information about how best to meet their needs.

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors. The practice had a health and safety policy. The practice manager showed us a number of risk assessments which had been developed and undertaken; including fire and health and safety risk assessments. Risk assessments of this type helped to ensure the practice was aware of any potential risks to patients, staff and visitors and was able to plan mitigating action to reduce the probability of harm.

The practice carried out significant event reporting where concerns about patients' safety and well-being had been identified. Appropriate arrangements were in place to learn from these and to promote learning within the team.

Arrangements to deal with emergencies and major incidents

The risks associated with anticipated events and emergency situations were recognised, assessed and managed.

The practice had an up-to-date business continuity plan for dealing with a range of potential emergencies that could impact on the day-to-day operation of the practice. Staff were able to easily access it if needed. 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.

Staff had received training in cardio-pulmonary resuscitation (CPR). Emergency equipment was available, including an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The staff we spoke with knew the location of this equipment and we were able to confirm that it was regularly serviced and well maintained.

Emergency medicines were available within the practice and all staff knew of their location. There was a laminated sheet that clearly listed the contents of the pack and this corresponded to the medicines available. Processes were also in place to check emergency medicines were within their expiry date and suitable for use.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff we spoke with were able to clearly explain why they adopted particular treatment approaches. They were familiar with current best practice guidance, and were able to access National Institute for Health and Care Excellence (NICE) guidelines via the practice IT system. For example, the clinical audits we looked at contained evidence that the GPs involved had been aware of changes in NICE guidance and patient safety alerts, and had ensured these were taken into account when reviewing the treatment patients had received.

From our discussions with clinical staff we were able to confirm they completed thorough assessments of patients' needs which were in line with NICE guidelines. Patients' needs were reviewed as and when appropriate. For example, we were told that patients with long-term conditions such as COPD (chronic obstructive pulmonary disease) were invited into the practice to have their condition and any medication they had been prescribed reviewed for effectiveness.

Clinical staff had access to a range of electronic care plan templates and assessment tools which they used to record details of the assessments they had carried out and what support patients needed. The GPs and practice nurses we spoke with told us there was a process in place for developing specific templates to reflect the needs of the practice and their patients, and ensure that these were in line with NICE guidelines.

Clinical responsibilities were shared between the clinical staff. For example, one of the GPs acted as the medicines lead for the practice. The clinical staff we spoke with were very open about asking for and providing colleagues with, advice and support.

Nationally reported data taken from the Quality Outcomes Framework (QOF) for 2013/14 showed the practice had achieved 96.1% of the points available to them for providing recommended treatments for the most commonly found clinical conditions. This was above both the local Clinical Commissioning Group (CCG) by 1.2 points and England averages by 2.6 points. 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 we spoke with said they felt well supported by the GPs and nursing staff with regards to making choices and decisions about their care and treatment. This was also reflected in most of the comments made by patients who completed Care Quality Commission (CQC) comment cards. Interviews with GP staff and practice nurses demonstrated the culture in the practice was, patients were referred to relevant services on the basis of need. Discrimination was avoided when making care and treatment decisions. Patients were referred on need and age, sex or race were not taken into account in this decision-making unless there was a specific clinical reason for this.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. For example, GPs held clinical lead roles in a range of areas such as mental health, learning disabilities, prescribing and for providing an allocated GP service to a local care home to maintain continuity. Other clinical and non-clinical staff had been given responsibilities for carrying out a range of designated roles, including for example, making sure emergency drugs were up-to-date and fit for use.

We reviewed a range of data available to us prior to the inspection relating to health outcomes for patients. These demonstrated that generally the practice was performing the same as, or better than average, when compared to other practices in England.

The practice had a system in place for completing clinical audit cycles. The practice showed us 12 clinical audits undertaken within the last few years. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, the practice audited the number of women offered a test for chlamydia (a common sexually transmitted disease) when they attended to have a contraceptive implant fitted. The reaudit demonstrated that all relevant patients had been offered a test for chlamydia. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

Good

Are services effective?

(for example, treatment is effective)

Other clinical audits completed included audits of minor operations, recording of skin markings on new born babies, assessment of cardiovascular health for patients on the mental health register and insertion of contraceptive implants and intrauterine devices (IUDs).

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the QOF. The practice provided us with a list of other audits and data collections they had undertaken to give reassurance in relation to the prescribing of medicines. For example, the practice had audited the patients who were at risk of having a stroke to ensure they were given the most appropriate preventative medication in line with national guidelines.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice was undertaking regular reviews of patients with diabetes for known risk factors. The practice met all the minimum standards for QOF in the management of long term conditions such as asthma, chronic obstructive pulmonary disease (lung disease) and epilepsy.

The practice had systems in place to identify patients, families and children who were most at risk or vulnerable. For example, practice staff told us that they had a register of patients who had a learning disability and also those with poor mental health. They also told us that annual health checks were carried out for patients on these registers. QOF data demonstrated that registers were in place and that patients were having their health needs assessed on a regular basis.

The practice had care plans for those identified at most risk of poor or deteriorating health. This was delivered as part of an enhanced service provided by the practice. This included care plans for patients with long-term conditions who were most at risk of deteriorating health and whose conditions were less well controlled; for the most elderly and frail patients and those with poor mental health. These patients all had a named GP or clinical lead for their care. We saw examples of these care plans and found them to be detailed and comprehensive. All patients over the age of 75 had been informed who their named GP was and had been given the opportunity to request another doctor if that was their preference.

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

For the last three years the practice had ran an annual workshop for young people to encourage emotional and physical well-being. Its aim was to improve self-esteem and confidence. The practice presented this at a Royal College of General Practitioners (RCGP) conference as an exemplar of health promotion.

The practice offered an enhanced service to the local linked care home. Each care home had a linked GP who visited regularly to meet the needs of patients living there.

There was a protocol for repeat prescribing which was in line with national guidance. In accordance with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP.

Staff checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

The practice held baby clinics on Wednesday and Friday afternoons, with open access appointments for Health Visitors and GP's.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up-to-date with attending mandatory courses such as basic life support. We saw there was a documented induction process for new employees.

Once a week the practice closed for an hour at lunch time for Protected Learning Time (PLT). A part of this time was dedicated to training. Role specific training was also provided. The practice nurses had been trained to administer vaccines and had attended updates on cervical screening.

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

Good

Are services effective?

(for example, treatment is effective)

appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed can the GP continue to practice and remain on the performers list).

All other staff had received an appraisal, at least annually, or more frequently if necessary. During the appraisals, training needs were identified and personal development plans put into place. Staff told us they felt supported. Our interviews with staff confirmed the practice was proactive in providing staff with access to appropriate training that was relevant to their role.

We looked at the practice staff rotas. Holidays, study leave and sickness were covered in-house wherever this was possible. Although administrative and support staff had clearly defined roles, they were also able to cover tasks for their colleagues in their absence. This helped to ensure the team were able to maintain the needed levels of support services at all times.

Working with colleagues and other services

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

We saw various multi-disciplinary meetings were held. For example, the practice held weekly palliative care meetings. This meeting was attended by the GPs, practice nurses, district nurses and health visitors. There were also quarterly meetings to discuss vulnerable children and those on child protection orders, attended by the practice clinical staff and health visitors.

District nurses, health visitors, midwives and Improving Access to Psychological Therapies (IATP) counsellors delivered services from the practice premises. The practice gave us anonymous case study examples of how this had helped communication between healthcare professionals, improved outcomes for patients and supported action taken to safeguard patients.

The practice received a list of unplanned admissions and attendance at accident and emergency (A&E) to support them to monitor this area. This helped to share important information about patients including those who were most vulnerable and high risk.

The practice worked with other service providers to meet patients' 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 to pass on, read and action 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 undertaking the action required. All staff we spoke with understood their roles and felt the system in place worked well.

We found appropriate end of life care arrangements were in place. The practice maintained a palliative care register. We saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider and the ambulance service.

The practice had developed links with local care services. Each care home linked to the practice had a named GP. The practice had visited a local young person's hostel to further develop relationships and let staff and young people know about the services offered by the practice.

GPs told us they worked well together as a team. An example of this was the buddy system in place for the review of test results should the patient's regular GP be absent from work for any reason. Weekly meetings for GPs were also held and were used to discuss cases, including any patients who were in receipt of palliative care. The practice gave us an example anonymous case study which demonstrated the way GPs worked together to meet the needs of patients.

Information sharing

An electronic patient record was used by all staff to coordinate, document and manage patients' care. A member of the reception team told us all staff were fully trained in using the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference

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.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We found that the majority of staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. Most clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. Decisions about, or on behalf of patients who lacked mental capacity to consent to what was proposed, were made in their best interests and in line with the MCA 2005. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment.

The practice told us the MCA 2005 was also a future topic planned for an upcoming Clinical Commissioning Group (CCG) 'time out' educational session.

GPs we spoke with showed they were knowledgeable about how and when to carry out Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

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.

Health promotion and prevention

New patients were offered a voluntary 'new patient check'. Patients were encouraged to undertake their own health check using facilities provided by the practice. This included a machine to check blood pressure and scales to check weight. Patient could submit this information for recording in their medical records. Where patients did not want to check their own health in this way, they were offered an appointment with practice staff. The patient was offered an appointment with a GP if there was a clinical need, for example, a review of medication.

Information on a range of topics and health promotion literature was available to patients in the waiting areas of both practice locations. This included information about screening services, smoking cessation and child health. Patients were encouraged to take an interest in their health and take action to improve and maintain it.

The practice's website also provided links to other websites and information for patients on health promotion and prevention. For example, the practice referred patients over the age of 50 to 'Information NOW' an information and advice website for people over 50 in Newcastle, their families and carers. Age UK provided an advice and support clinic each week from the practice premises. This helped older people access services relevant to them.

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. Staff told us this system worked well and prevented any patient groups from being overlooked. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for immunisations was in line with averages for the Clinical Commissioning Group (CCG). For example, Infant Meningitis C vaccination rates for two year old children were 98.6% compared to 95.5% across the CCG; and for five year old children were 94.5% compared to 93.9% across the CCG. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination, was above the national average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with eight patients during our inspection. They were all happy with the care they received. Patients told us they were treated with respect and were positive about the staff. They told us they would recommend the practice to family and friends. Comments provided by patients in the 78 CQC comment cards we received also reflected this. Words used to describe the approach of staff included 'pleasant', 'helpful', 'friendly', 'professional' and 'knowledgeable'.

We looked at data from the National GP Patient Survey, published in January 2015. This demonstrated that patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. We saw that 99.1% (compared to 92.5% nationally) of patients said they had confidence and trust in their GP and 92.5% (compared to 82.7% nationally) said their GP was good at treating them with care and concern.

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. Many of the comments in the Care Quality Commission (CQC) comment cards referred to the helpful nature of staff. This was reflective of the results from the National GP Survey where 95.4% of patients felt the reception staff were helpful, compared to a national average of 87.3%.

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

We saw staff who worked in the reception areas made every effort to maintain patients' privacy and confidentiality. Voices were lowered and personal information was only discussed when absolutely necessary. Telephone calls from patients were taken by administrative staff in an area where confidentiality could be maintained.

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

The practice had policies in place to ensure patients and other people were protected from disrespectful, discriminatory or abusive behaviour. The staff we spoke with were able to describe how they put this into practice.

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, the survey showed 80.2% of respondents said the GP was good at involving them in care decisions and 82.7% 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. The majority of patient feedback in the 78 CQC comment cards we received was also positive and supported these views.

We saw that access to interpreting services was available to patients, should they require it. They said when a patient requested the use of an interpreter, staff could either book an interpreter to accompany the patient to their appointment or, if it was an immediate need, then a telephone service was available. There was also the facility to request translation of documents should it be necessary to provide written information for patients.

Patient/carer support to cope emotionally with care and treatment

We observed patients in the reception area being treated with kindness and compassion by staff. None of the

Good

Are services caring?

patients we spoke with, or those who completed CQC comment cards, raised any concerns about the support they received to cope emotionally with their care and treatment.

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated them well in this area. For example, 92.5% of those surveyed thought the GPs they saw or spoke to was good at treating them with care and concern. Similarly, 82.3% thought nurses did. These were both higher than national averages.

We did not see any evidence during the inspection of how children and young people were treated by staff. However, neither the patients we spoke to, nor those who completed CQC comment cards, raised any concerns about how staff looked after children and young people. We saw evidence the practice supported children in transitioning from using children to adult services, for example those with diabetes.

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups.

The practice routinely asked patients if they had caring responsibilities. This was then noted on the practice's computer system so it could be taken into consideration by clinical staff.

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 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 patients' wishes at these times.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided a service for all age groups. They covered patients with diverse cultural and ethnic needs and those living in deprived areas. We found GPs and other staff were familiar with the individual needs of their patients and the impact of the local socio-economic environment. Staff understood the lifestyle risk factors that affected some groups of patients within the practice population. We saw the practice referred people to the local services, where the aim was to help particular groups of patients to improve their health. For example, smoking cessation programmes, and advice on weight and diet.

Staff told us that where patients were known to have additional needs, such as being hard of hearing, were frail, or had a learning disability, this was noted on the medical system. We saw anonymous examples of these. This meant the GP or nurses would already be aware of this and any additional support could be provided, for example, a longer appointment time.

Longer appointments were made available for people who needed them and for those with long-term conditions. This also included appointments with a named GP or nurse. Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the national GP patient survey published in January 2015 confirmed this. 93.7% of patients felt the doctor gave them enough time and 82.9% felt they had sufficient time with the nurse. These results were above the national averages (85.3% and 80.2% respectively).

The practice was working towards the basic criteria on the "You're Welcome "programme to improve accessibility for young people. This programme sets out a set of quality criteria for youth-friendly health services The practice contacted all young patients when they reach age 16 to tell them about the practice and the services they offered.

The practice had a well-established Patient Participation Group (PPG). We spoke with three members of the group who said they felt the practice valued their contribution. The practice shared relevant information with the group and ensured their views were listened to and used to improve the service offered at the practice. For example, PPG members told us they had been consulted and their views taken into account when setting questions within the practice patient questionnaire.

Tackling inequity and promoting equality

Three patients provided feedback within the CQC comment cards about the difficulty in accessing the practice if you used a wheelchair. They told us it was not possible to enter the building unaided if you used a wheelchair. Although the practice had a ramp leading from the street to the main door, the angle of this ramp was too steep. We spoke with one of these patients to gather more detail about their concerns. They also told us some of the consultation rooms and corridors were difficult to navigate in a wheelchair. Although the practice had agreed some reasonable adjustments to allow them to access the service, these had not always been followed and had not always worked well. They told us there was no way of calling for assistance if you were unable to make it up the entrance ramp.

We spoke with the practice about the arrangements they had in place to support patients with disabilities to access the service. The practice were aware of the concerns about accessibility for patients in wheel chairs. They told us there were limitations within the practice premises which meant they were unable to make all consultation and treatment rooms accessible for all. Two consultation rooms were based on the first floor and there was no lift access available between the ground and this floor. Similarly some of the rooms on the ground floor had steps to access them.

The practice was in progress of making plans to address the concerns about accessibility of the premises. The practice had sought professional advice about making alterations to the premises to increase accessibility. This included architectural plans for a chicane style ramp from the street to the main door. (This is a ramp with a number of turns to lower the angle of the ramp over a small surface area.) The practice had submitted a bid for an NHS England Improvement Grant in February 2015 to allow this work to be undertaken. They showed us the bid and supporting paperwork. They had yet to hear if this bid had been accepted.

In the meantime, the practice told us they had made reasonable adjustments to allow those who were unable or found it difficult to use steps and stairs to access the service. This included only using the upstairs consultation rooms when there were also appointments available in

Good

Are services responsive to people's needs?

(for example, to feedback?)

accessible rooms on the ground floor. For example, downstairs consultation rooms were utilised during extended opening hour appointments. They also told us patients had the option of requesting a home visit, where their needs could not be met within the practice premises. They showed us an anonymous example of the 'pop up' notes within patient records, which reflected the reasonable adjustments they had agreed with a patient. There was a note on the practice website informing patients about problems with accessibility to some areas of the practice premises and the action to take if the patient required an appointment in an accessible consultation room.

In other aspects the services had been designed to reflect the needs of the diverse population served by the practice. The practice had access to and made frequent use of translation services, for those patients who did not speak English as a first language.

Accessible toilet facilities were available for all patients attending the practice, including baby changing facilities.

The practice provided staff with equality and diversity training. Staff we spoke with confirmed that they had completed this training.

The practice had invited Skills for People to visit the practice and check on the arrangements for meeting the healthcare needs of patients with learning disabilities. This was undertaken as part of a Health Quality Checkers visit in September 2014. Skills for People is a user-led, voluntary organisation working in the North East for people with disabilities, and particularly learning disabilities. During the visit, the Health Checkers gave a talk to practice staff about what it was like to be a patient with a learning disability accessing GP and Nurse appointments. (The Health Checkers were people with a learning disability who had been trained by Skills for People to undertake these visits.) The visit highlighted areas the practice was good at, such as having a lead GP for patients with learning disabilities. The practice showed us the easy read information they had implemented since the visit. This included an easy read Health Action Plan for patients to complete. A Health Action Plan is a personal plan about what a person with learning disabilities can do to be healthy.

For patients on the palliative care register and for the most elderly and frail patients the practice supported them by offering access, with a response within 24 hours, to a GP via phone when required.

Access to the service

Appointments were available on Monday and Tuesday 8:00am to 8:00pm, Wednesday, Thursday and Friday 8:00am to 6:30pm. We checked the availability of appointments on the day of our inspection. We found there were appointments available on the day for both doctors and nurses.

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 patients had access to the right care at the right time. The National GP Patient Survey results showed that 89.6% of patients were satisfied with opening hours, compared to a national average of 76.9%.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when they were closed, an answerphone message gave the telephone number they should ring depending on the circumstances. The practice website also provided information targeted at young people about what services the practice offered and how they could access these.

Listening and learning from concerns and complaints

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

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.

The complaints policy was outlined in the practice leaflet and was available on their website. The practice also had a comments box situated in the entrance foyer to enable patients to provide feedback about the service provided.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Of the eight patients we spoke with, and the feedback we received from the 78 CQC comment cards completed by patients, none raised concerns about the practice's approach to complaints.

We looked at the summary of complaints that had been received in the 12 months prior to our inspection. We found 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. Changes had been implemented where necessary.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice website clearly set out the mission statement for the practice. This included a commitment to provide high quality patient care in all areas, clinical and non-clinical, to all their patients regardless of age, colour, sex or religion.

The practice had a business plan in place, with key business objectives that were reviewed at each quarterly strategic partners meeting. The plan set out the key priorities for the practice and how they would be achieved. This was communicated to staff through team and practice meetings. It was evident in discussions we had with staff throughout the day that it was a shared vision and was fully embedded in staff's day-to-day practice.

We spoke with 14 members of staff and they all knew the provision of high quality care for patients was the practice's main priority. They also knew what their responsibilities were in relation to this and how they played their part in delivering this for patients.

The three members of the Patient Participation Group (PPG) we spoke with told us the practice was open in their approach and they had clearly shared the vision and strategy for the practice with members of the PPG. They told us the practice was very good at giving feedback to the PPG, including where potential improvements were not viable or would not achieve the expected outcomes.

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 they had been reviewed regularly and were up-to-date.

The practice held regular staff, clinical and practice meetings. We looked at minutes from recent meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) as an aid to measure their performance. The QOF data for this practice showed they were performing above the local Clinical Commissioning Group (CCG) and England averages. 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.

The practice had completed a number of clinical and internal audits. The results of these audits and re-audits demonstrated outcomes for patients had improved.

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 GP had leads in areas such as long-term conditions, and learning disabilities and safeguarding of children and vulnerable adults. We spoke with 14 members of staff and they were all clear about their own roles and responsibilities.

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 any incidents or concerns about the practice. This ensured honesty and transparency was at a high level.

We found the practice leadership proactively drove continuous improvement and staff were accountable for delivering this.

There was a clear and positive approach to seeking out and embedding new ways of providing care and treatment. For example, the practice was investigating the reasons for patient attendance at Accident and Emergency Departments (A&E) where patients could have otherwise been seen at the practice to support the reduction of unnecessary A&E attendance. The business plan in place identified priorities and supported the practice with improving quality within the practice.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff, for example, whistleblowing and safe recruitment policies. These were easily accessible to staff via a shared intranet on any computer within the practice.

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

The practice had gathered feedback from patients through patient surveys, comments and complaints received.

The practice had a patient participation group (PPG). This met every three months.

Are services well-led?

Good

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

The practice manager showed us the analysis of the last patient survey they had carried out, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. We spoke with three members of the PPG, who all spoke positively of the way they were engaged and listened to by practice staff. They told us the practice had listened to their feedback and as a result changed the practice reception desk area to be more open and welcoming to patients. The practice published an annual report into the work of the PPG and this was available on the practice website. Minutes of PPG meetings were also available on the practice website.

A practice newsletter was published on the practice website, and we saw the January newsletter.

NHS England guidance states that from 1 December 2014, all GP practices must implement the NHS Friends and Family Test (FFT). (The FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices). We saw the practice had recently introduced the FFT. There were questionnaires available at the reception desk and instructions for patients on how to give feedback. The practice manager told us the comments and feedback would be reviewed regularly.

The practice 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 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 would not hesitate to raise any concerns they had.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place. Staff members had personal development plans. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. Staff meeting minutes showed these events were discussed, with actions taken to reduce the risk of them happening again.