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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Bedlingtonshire Medical Group on 2 February 2016. Overall the practice is rated as outstanding.

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

- People were protected by a strong comprehensive safety system and a focus on openness, transparency and learning when things go wrong.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice.
- Feedback from patients about their care was consistently and strongly positive.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example, they had implemented a change to the telephone system which allowed patients who could not press buttons (such as those with arthritis) to speak to a receptionist quicker than they could previously.
- The practice was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.

We saw several areas of outstanding practice including:

- The practice had implemented a number of initiatives as part of their High Risk pathway, which was designed to manage patients at risk of unplanned hospital admissions. These included a review of prescribing which had reduced unnecessary repeat prescriptions by 16%, and the development of their own

Summary of findings

evidence-based care plans to allow patients with respiratory conditions to manage them at home. Since implementing these measures the practice had reduced unplanned hospital admissions for their patients from 239 in 2013/14 to 99 in 2015/16. Some of these iniatives had been adopted by the local clinical commissioning group (CCG) and extended to practices across the region.

- The practice manager had designed and implemented an evidence-based system for reporting and analysing significant events. This had created a culture which prioritised safety and learning in the practice, and resulted in an increase from 11 significant events reported in 2013 to 54 in 2015, driving a number of improvements at the practice. Where the practice did not achieve 100% of the Quality and Outcomes Framework points available for a particular domain a significant event analysis was performed to learn what could be improved. All staff, adminisitrative and clinical, were included in this process, and patients were invited to be involved to suggest ways to improve.
- A practice nurse with experience of minor illness care had been employed to implement a minor illness clinic at the practice. They created an evidence-based minor illness triage pathway developed for receptionists, and any patients who fit the criteria on the list could be given an appointment with the nurse instead of a GP. Minor illness appointments were blocked out for these patients, creating on average 25 additional GP appointments per day.

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?

Outstanding 

The practice is rated as outstanding for providing safe services.

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The practice used every opportunity to learn from significant incidents to support improvement. Learning was based on a thorough analysis and investigation.
- Information about safety was highly valued and was used to promote learning and improvement.
- The importance of significant event reporting, and what to report and how, formed a key part of the induction process for all staff, including apprentices.
- Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. Staff took lead roles to monitor risk, for example there was a lead for monitoring medical devices.
- The practice had employed a pharmacist to ensure that medications were stored safely and prescriptions were appropriate for the patient.
- Audits to monitor safety were backed up with quarterly compliance checks.

Are services effective?

Outstanding 

The practice is rated as outstanding for providing effective services.

- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. The practice had a clinical lead for NICE guidance who helped staff remain up to date.
- We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients.
- Data showed that the practice was performing highly when compared to practices nationally and in the clinical commissioning group (CCG). The practice achieved 99.6% of the total number of Quality and Outcomes Framework points available (CCG average 97.6%, national average 93.5%), with 6.5% exception reporting (CCG average 9.3%, national average 9.2%). They were above local and national averages for all domains.

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- Where the practice did not achieve 100% of QOF points available for a particular domain a significant event analysis was performed to learn what could be improved. All staff, adminisitrative and clinical, were included in this process.
- The practice used innovative and proactive methods to improve patient outcomes and working with other local providers to share best practice. For example, they had employed a pharmacist to implement a review of medications in care homes visited by the practice which was now being extended across the CCG.
- The practice had implemented a number of initiatives that had reduced unplanned hospital admissions for their patients from 239 in 2013/14 to 99 in 2015/16.
- Staff held weekly with multidisciplinary teams, and daily meetings within the practice, to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs.
- There were innovative approaches to providing integrated person-centred care. For example, an acupuncture service was provided by one of the partners, which had reduced referral to secondary care and prescribing of analgesics to patients who used this with a success rate of approximately 70%.
- The practice had employed a Patient Services Manager to be a direct point of contact for patients to give feedback. They implemented suggestions for improvements and made changes to the way it delivered services as a consequence of

Summary of findings

feedback from patients and from the patient participation group. For example, they had changed the telephone system to make it easier to use for patients who were unable to press buttons to select options.

- A minor illness triage system had been created by the practice. Minor illness appointments with a practice nurse were set aside for patients who met the criteria, to reduce the demand for GP appointments.
- Patients could access appointments and services in a way and at a time that suited them. The practice was pro-active in offering text and online services, including the option for patients to communicate directly with GPs via an online messaging system.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders. Learning from compliments was also shared.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for being well-led.

- The practice had a clear vision with quality and safety as their top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- High standards were promoted and owned by all practice staff and teams worked together across all roles.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.
- The practice carried out proactive succession planning. When a GP partner had left the practice, they had replaced them with two salaried GPs in order to increase the number of appointments available.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- The practice gathered feedback from patients using new technology, and they had a very active patient participation group which influenced practice development.

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, as the practice is rated as outstanding overall.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those over 75 years old.
- The nurse practitioner performed a weekly “ward round” at the six care homes where the practice had patients.
- Staff from the practice provided training to staff in the care homes to improve outcomes for patients. For example, the nurse practitioner had helped a care home to develop a protocol for administering sub-cutaneous fluids to reduce patients’ risk of dehydration.
- The practice operated a dedicated telephone line for the care homes and hospitals so that they could access staff directly.
- A review of medications prescribed to patients at the six care homes where the practice had patients had reduced unnecessary prescriptions by 16%.
- The practice had helped a local carers organisation to develop a Do Not Attempt Resuscitation (DNAR) policy, to protect patients and carers.

People with long term conditions

Outstanding ☆

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority and discussed weekly.
- The practice had implemented a number of initiatives that had reduced unplanned hospital admissions for their patients from 239 in 2013/14 to 99 in 2015/16.
- Performance for diabetes related indicators was better than the CCG and national average. For example 94.4% of patients on the diabetes register had a record of a foot examination and risk classification within the preceding 12 months (01/04/2014 to 31/03/2015) compared to a national average of 88.3%.
- Longer appointments and home visits were available when needed.

Summary of findings

- All these patients had a named GP and were offered a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice had developed their own evidence-based care plans to allow patients with conditions such as asthma and chronic obstructive pulmonary disease to manage their conditions at home. Patients were regularly followed-up by a practice nurse with specialist experience of managing these conditions.
- The practice held a daily meeting to discuss referrals and complex patients, such as those with long-term conditions.
- An acupuncture service was provided by one of the partners, reducing referral to secondary care and prescribing of analgesics to patients who used this with a success rate of approximately 70%.

Families, children and young people

Outstanding ☆

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

- 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. For example, rates for under two year olds ranged from 98.5% to 100% and five year olds from 95.1% to 99.3% (CCG averages 97.6% to 97.9% and 94.9% to 98.5% respectively).
- The time and length of appointments at the baby immunisation clinic was changed to ensure more school and nursery age children could attend.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Summary of findings

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the care of working age people (including those recently retired and students), as the practice is rated as outstanding overall.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice offered "overspill" clinics on days when there was high demand for appointments, and extended hours were offered from 7am on Tuesdays and until 8.15 pm on Wednesdays.
- 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. For example, they offered online access to book appointments, order repeat prescriptions, send special requests or email messages for doctors.
- The practice's uptake for the cervical screening programme was 81.2%, which was comparable to the national average of 81.8%. The practice was part of the CCG initiative to offer a personalised "pink letter" for patients who did not attend.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people who circumstances may make them vulnerable, as the practice is rated as outstanding overall.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients those who needed them.
- The practice worked with multi-disciplinary teams in the case management of vulnerable people, and held weekly meetings to monitor their care.
- The practice informed 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.

Summary of findings

People experiencing poor mental health (including people with dementia)

Outstanding

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia), as the practice is rated as outstanding overall.

- 84.2% of patients diagnosed with dementia who had had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average of 84%.
- Performance for mental health related indicators was better than national average. For example, 94% of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded in the preceding 12 months (April 2014 to March 2015) compared to the national average of 89.6%.
- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.
- The practice was able to offer early diagnosis of dementia and begin advance care planning for these patients.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had undergone “Dementia Friends” training with a national charity, and had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing above local and national averages. 262 survey forms were distributed and 102 were returned. This represented a response rate of 38.9%, and accounted for approximately 1% of the practice's patient list.

- 93% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area compared to a clinical commissioning group (CCG) average of 81.2% and a national average of 77.5%.
- 90.4% described the overall experience of their GP surgery as fairly good or very good (CCG average 87.1%, national average 84.8%).
- 90.5% were able to get an appointment to see or speak to someone the last time they tried (CCG average 85.9%, national average 85.2%).
- 84.5% feel they don't have to wait too long to be seen (CCG average 67.7%, national average 57.7%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 39 comment cards, 37 of which were positive about the standard of care received. Comments we received said all staff were caring, friendly and polite, while a number noted that they found it easy to make appointments. The two cards which were not positive about the service said they found it difficult to make an appointment.

We spoke with six patients during the inspection. All six patients said they were happy with the care they received and thought staff were approachable, committed and caring. In 2015 the practice had 197 responses to their Friends and Families Test, with 172 patients (87.3%) responding that they would be likely or highly like to recommend the practice. Comments patients gave reflected those we received on our comment cards.

Outstanding practice

We saw several areas of outstanding practice including:

- The practice had implemented a number of initiatives as part of their High Risk pathway, which was designed to manage patients at risk of unplanned hospital admissions. These included a review of prescribing which had reduced unnecessary repeat prescriptions by 16%, and the development of their own evidence-based care plans to allow patients with respiratory conditions to manage them at home. Since implementing these measures the practice had reduced unplanned hospital admissions for their patients from 239 in 2013/14 to 99 in 2015/16. Some of these iniatives had been adopted by the local clinical commissioning group (CCG) and extended to practices across the region.
- The practice manager had designed and implemented an evidence-based system for reporting and analysing significant events. This had created a culture which prioritised safety and learning in the practice, and resulted in an increase from 11 significant events reported in 2013 to 54 in 2015, driving a number of improvements at the practice. Where the practice did not achieve 100% of the Quality and Outcomes Framework points available for a particular domain a significant event analysis was performed to learn what could be improved. All staff, adminisitrative and clinical, were included in this process, and patients were invited to be involved to suggest ways to improve.
- A practice nurse with experience of minor illness care had been employed to implement a minor illness clinic at the practice. They created an evidence-based minor illness triage pathway developed for receptionists, and any patients who fit the criteria on the list could be given an appointment with the nurse instead of a GP. Minor illness appointments were blocked out for these patients, creating on average 25 additional GP appointments per day.

Bedlingtonshire Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Bedlingtonshire Medical Group

Bedlingtonshire Medical Group is registered with the Care Quality Commission to provide primary care services.

The practice provides services to approximately 11,000 patients from one location at Glebe Road, Bedlington, Northumberland, NE22 6JX. This is the location we visited on the day of our inspection.

The practice is based in a purpose-built surgery shared with other local healthcare services, such as health visitors and district nurses. The building is owned and managed by NHS Property Services Limited and has level-entry access and a car park for patients to use. All the services provided to patients by Bedlingtonshire Medical Group are on the ground floor.

The practice has 30 members of staff, comprising two GP partners (both male), four salaried GPs (one male, three female), one GP registrar (female), one foundation doctor (male), one nurse practitioner (female) three practice nurses (all female), two healthcare assistants (one male, one female), a pharmacist, a four-person practice management team (including the practice manager and a patient services manager) and reception/administrative staff.

The practice is part of Northumberland clinical commissioning group (CCG). Information taken from Public Health England placed the area in which the practice was located in the fifth least deprived decile. In general, people living in more deprived areas tend to have greater need for health services.

The surgery is open from 8am until 6pm, Monday to Friday. Additionally, the practice operates earlier opening hours on Tuesdays from 7am, and later appointments on Wednesdays until 8.15pm. The telephone lines operate at all times during these opening hours. Outside of these times, a message on the surgery phone line directs patients to out of hours care, NHS 111 or 999 emergency services as appropriate. Appointments with a GP are available as follows:

- Monday: 8am-11am and 1.30pm-6pm
- Tuesday: 7am-11am and 1.30pm-6pm
- Wednesday: 8am-11am, 1.30pm-6pm and 6.30pm-8.15pm
- Thursday: 8am-11am and 1.30pm-6pm
- Friday: 8am-11am and 1.30pm-6pm

The practice provides services to patients of all ages based on a Personal Medical Services (PMS) contract agreement for general practice. The practice population roughly reflects national averages for age distribution, although there are slightly fewer patients than average between the ages of 20 and 39. The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and Northern Doctors Urgent Care Limited.

Detailed findings

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 2 February 2016. During our visit we:

- Reviewed information available to us from other organisations, for example, NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Spoke to staff and patients.
- Looked at documents and information about how the practice was managed.
- Reviewed patient survey information, including the NHS GP Patient Survey.
- Reviewed the practice's policies and procedures.

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 CQC at that time.

Outstanding ☆

Are services safe?

Our findings

Safe track record and learning

There was a highly effective system in place for reporting and recording significant events.

- There was a genuinely open culture within the practice in which all safety concerns raised by staff and people who use services were highly valued as integral to learning and improvement. Significant event reporting was part of the induction programme for all new staff, including apprentices. As a result, all staff we spoke told us about the value of reporting significant events and fully understood their role in this, as well as their role in assisting investigations where appropriate.
- Staff told us they would inform the practice manager of any incidents, positive or negative, which could result in improvements to patient safety being made. They were aware there was a recording form available on the practice's computer system and knew how to use it.
- Concerns raised by patients at reception which were not submitted as formal written or verbal complaints were logged as significant events so that they could be investigated to look for trends.
- Learning was based on a thorough analysis and investigation of things that go wrong. In 2014 the practice manager designed and implemented a system for reporting and analysing significant events based on the Seven Steps to Patient Safety for Primary Care by the National Patient Safety Agency. This resulted in an increase in reporting, from 11 significant events in 2013 to 54 in 2015. Significant events were entered onto a database where they were categorised by type (for example, clinical incident or information governance breach) and level of severity. These were then reviewed monthly and annually to look for trends. For example, repeated administrative errors had been noted and systems had been put in place to prevent these. Records were kept of significant events that had occurred during the last 10 years and these were made available to us.
- Significant events were discussed at a monthly significant event analysis (SEA) meeting, as well as at relevant monthly team meetings and practice meetings. Any event requiring immediate action was discussed at the practice's daily referrals meetings. The whole team was engaged in reviewing and improving safety. The outcomes of significant events were reported back to staff at an individual level and at meetings. Minutes of meetings were available to read for staff who could not attend.
- Information and learning pertaining to significant events was shared with external agencies using the Safeguard Incident and Risk Management System (SIRMS), which is an online incident reporting system. Opportunities to learn from external safety events were identified.

We reviewed safety records, incident reports, national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, following a vaccination error during a baby clinic the way in which the clinic was run was changed to ensure that staff had more time to concentrate on preparing vaccinations whilst still being able to answer parents' questions. As well as extending appointment times, another nurse assisted with the clinic so that one nurse could focus solely on preparing vaccinations while the other spoke to the parents and checked records. They also took the opportunity to change the timing of the clinic to make it easier for parents with children at school or nursery to attend.

As well as implementing changes when significant events occurred, the practice analysed the impact of these changes to ensure they were effective. For example, when changes were made to the way in which emergency medications were stored following a significant event, it was agreed that the new system would be reviewed after every emergency event to look for improvements.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again. They were also included in the investigation of significant events, where appropriate. For example, following the significant event at the baby immunisation clinic patients were informed of what had happened and asked to complete a survey asking for their feedback on the clinic and how changes could be made.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

Outstanding ☆

Are services safe?

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to safeguarding children level three.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The nurse practitioner was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken, as well as quarterly compliance checks to ensure that action was taken to address any improvements identified as a result of audits. We saw evidence that improvements were made where required.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice employed a pharmacist to carry out regular medicines audits, with the support of the local CCG pharmacy teams, to monitor repeat prescriptions and ensure prescribing was in line with best practice guidelines for safe prescribing. This had reduced the number of repeat prescriptions issued by the practice. Prescription pads were securely stored and there were systems in place to monitor their use. Some of the nursing staff had qualified as Independent Prescribers and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- The practice had developed risk assessments that they were able to share with external agencies. For example, they had developed a health and safety risk assessment and pre-placement health/disability questionnaire for medical students which was shared with Health Education England at their request, and will be used by them to assess medical students undertaking placements in general practice.
- The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. There was a lead staff member for checking clinical equipment to ensure it was working correctly. All electrical equipment was checked to ensure the equipment was safe to use, and records were kept of dates when equipment was bought and serviced so that preventative maintanence of equipment could be planned.

Outstanding ☆

Are services safe?

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Services were flexible to cope with changing demand due to staffing, for example more appointments for the nurse-led minor illness clinic were offered on days when fewer GPs were available.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. Copies were held off site and online.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs.
- There was a clinical lead for NICE guidance who undertook a monthly review of new guidance and provided a summary of this to relevant staff. This was then discussed at monthly practice meetings.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. They also discussed guidelines at monthly practice education meetings.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the practice had achieved 99.6% of the total number of points available (clinical commissioning group (CCG) average 97.6%, national average 93.5%), with 6.5% exception reporting (CCG average 9.3%, national average 9.2%). (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed;

- Performance for diabetes related indicators was better than the CCG and national average. For example 94.4% of patients on the diabetes register had a record of a foot examination and risk classification within the preceding 12 months (April 2014 to March 2015) compared to a national average of 88.3%.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average at 91.6% (national average 83.7%).
- Performance for mental health related indicators was better than national average. For example, 94% of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded in the preceding 12 months (April 2014 to March 2015) compared to the national average of 89.6%.
- Performance for respiratory disease related indicators was better than national average. For example, 89.9% of patients with chronic obstructive pulmonary disease (COPD) had received a review by a healthcare professional which included an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (national average 79.9%). Exception reporting for these indicators was also very low (2.4% compared to the national average of 11.1%)

All staff were actively engaged in monitoring and improving quality and outcomes. Where scores were below CCG and national averages this was logged as a significant event to allow for a full investigation to understand why. This involved the whole practice team, both clinical and administrative. In 2014/15 the only area where the practice was below average was for monitoring patients receiving medication for severe depression, and an audit was completed to look for ways in which the practice could improve. This had found that some patients receiving this medication had not been given a patient information booklet to explain the importance of attending regular reviews whilst taking the medication. All patients receiving the medication at the practice had now received a booklet.

Clinical audits demonstrated quality improvement.

- There had been four clinical audits in the last two years; three of these were completed two-cycle audits where the improvements made were implemented and monitored. These focussed on the prescription of weight loss medication, the treatment of acne, and the prescription of medication to treat anxiety and insomnia. All three demonstrated improvements in treatment and prescribing in these areas among clinical staff.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.

- Staff from across the clinic team were encouraged to be involved in carrying out clinical audits, including nursing staff and foundation doctors.
- Findings were used by the practice to improve services. For example, recent action taken as a result included a reduction in the prescribing of sleeping medication and a reduction in repeat prescriptions made without a review by a GP.
- The practice held monthly training meetings where audits and their outcomes were discussed.

Staff, teams and services were committed to working collaboratively, people who had complex needs were supported to receive coordinated care, and there were innovative and efficient ways to deliver more joined-up care to people who use services. For example, the practice was proactive in implementing a High Risk Register. This was an initiative in which the practice worked with other health professionals to monitor the care of the 2% of patients on the practice list who were deemed to be most at risk of unplanned hospital admission. The nurse practitioner was the nominated lead for the initiative in the practice, and they co-ordinated weekly multi-disciplinary team (MDT) meetings with district nurses, social workers and GPs to decide which patients would benefit most from inclusion on the list. Care plans for these patients were developed by the multi-disciplinary team together with patients and their family, where appropriate, and these were shared with out of hours care providers.

While the initiative was introduced by the CCG, the practice had combined this with their own projects which had resulted in measured benefits to staff and patients. The nurse practitioner had initiated a weekly meeting with clinical staff and patients at the six care homes where patients of the practice were residents. The care homes were given a handover form to write down all concerns about practice patients in their care, and these would be discussed with the nurse practitioner at weekly visits. The nurse practitioner worked closely with the CCG Elderly Care Physician and with patients themselves to develop care plans which could be implemented by the care home staff. This process had reduced the demand on GPs at the practice by reducing the number of calls made to them by the homes, and increased continuity of care for patients at the care homes. We spoke to the manager of one of the care homes who told us that feedback from the patients and staff about the service had been very positive. They told us that Bedlingtonshire Medical Group was the only practice they worked with who offered this service. They also told us that the nurse practitioner had worked with staff at the home to develop a protocol for them to administer sub-cutaneous fluids to patients. This was to help to reduce patients' risk of dehydration, which had been one of the leading causes of unplanned hospital admissions among patients at the home.

The practice had also employed a pharmacist who had worked on a project (Shine) to reduce unnecessary prescribing, with the aim of implementing the project across the six care homes. By reviewing medications at the care homes they had reduced unnecessary repeat prescriptions by 16%. This had received positive feedback from patients, as well as producing financial benefits. Due to its success, this project was due to be expanded across the CCG area.

Residents at the care homes were included in the high risk register and their care was discussed at the weekly MDT meeting. Since the implementation of these measures the practice had reduced unplanned hospital admissions for their patients from 239 in 2013/14 to 99 in 2015/16.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety, confidentiality, and significant event reporting.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for example, for those reviewing patients with long-term conditions. Staff administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example, by access to on line resources and discussion at practice meetings.
- The practice was proactive to employ staff to provide specific services. For example, the practice had actively sought a practice nurse with experience of respiratory care to provide services to patients based on a

higher-than-average prevalence of respiratory conditions in their area. They had also appointed a pharmacist from the Shine project specifically to implement the initiative at their practice.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.
- The practice had monthly clinical education meetings, where staff would present findings of audits, feedback from training they had attended, or where external speakers would be invited to hold training sessions.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that daily referral meetings took place, where patients who needed urgent follow up could be discussed, while multi-disciplinary team meetings were held on a monthly basis. Care plans were routinely reviewed and updated.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. Consent practices and records were actively monitored and reviewed to improve how people were involved in making decisions about their care and treatment.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. A note on the practice computer system automatically brought up a link to guidance on assessing Gillick competence when a patient was under 16 years old. Gillick competence is an assessment of a child or young person's ability to consent to medical treatment without the need for parental permission or knowledge.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through records audits.

Supporting patients to live healthier lives

Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health, and every contact with people was used to do so.

- This included supporting patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and patients who may be at risk of developing dementia. Patients were then signposted to the relevant service.
- Staff took lead roles in management of long-term conditions, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). They had developed self-management plans based on national guidance which patients could use to help them manage their conditions without the need for hospital admission. The plans allowed patients to monitor when their conditions worsened to look for triggers which caused this. They also gave patients prompt advice

about what to do if they felt their condition was getting worse. Patients with these conditions were kept on a register and regularly reviewed. If they attended hospital due to a deterioration in their condition the practice nurse contacted them for an immediate review. These patients were also on the high risk register kept by the practice, which had demonstrated a reduction in unplanned hospital admissions.

The practice's uptake for the cervical screening programme was 81.2%, which was comparable to the national average of 81.8%. The practice was part of the CCG initiative to offer a personalised "pink letter" for patients who did not attend for their cervical screening test, which staff felt had resulted in an uptake in attendance. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and ensured a female sample taker was available. They had a clinical lead for cervical screening who monitored uptake and sought ways to improve it. This included placing a note on the system for staff to remind relevant patients about cervical screening when they attended the practice for other reasons. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 98.5% to 100% and five year olds from 95.1% to 99.3% (CCG averages 97.6% to 97.9% and 94.9% to 98.5% respectively).

Flu vaccination rates for the over 65s were 82.2%, and at risk groups 61.1%. These were above national averages of 73.2% and 57.3% respectively.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Clinical staff at the practice had undertaken training to be able to give a general diagnosis of dementia, thereby allowing them to implement appropriate care at an early stage. Patients were referred on to other services for a more specific diagnosis and for the prescription of medication, but the practice was able to initiate advanced care planning. The practice had set an initial diagnosis target of 63%, but currently had a rate of 69.05%.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Of the 39 patient Care Quality Commission comment cards we received, 37 were entirely positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two members of the patient participation group. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected when they visited as patients. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice were in line with or above local and national averages for their satisfaction scores on consultations with GPs and nurses. For example:

- 92.4% said the GP gave them enough time compared to the clinical commissioning group CCG average of 88.8% and national average of 86.6%.
- 89.9% said the GP was good at listening to them (CCG average 90.6%, national average 88.6%).
- 88.5% said the last GP they spoke to was good at treating them with care and concern (CCG average 88.2%, national average 85.1%).
- 97.9% said the last nurse they spoke to was good at listening to them (CCG average 93.4%, national average 91%).
- 98.7% said the last nurse they spoke to was good at giving them enough time (CCG average 94.5%, national average 91.9%).
- 88.4% said they found the receptionists at the practice helpful (CCG average 88.6%, national average 86.8%)

Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with or above local and national averages. For example:

- 90.5% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89.3% and national average of 86%.
- 87.7% said the last GP they saw was good at involving them in decisions about their care (CCG average 85.7%, national average 81.4%)
- 97.5% said the last nurse they saw was good at explaining tests and treatments (CCG average 91.9%, national average 89.6%)

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 236 patients (approximately 2%) of the practice list as carers. Written information was available to direct carers to the various avenues of support available to them. The Patient Services Manager regularly met with local carers groups to gather

Good

Are services caring?

further information about services in the area which was then fed back to staff at team meetings. Carers groups were also invited to attend flu vaccination clinics to offer opportunistic advice to patients and family members.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Bereavements were discussed in the daily referrals meeting and the most appropriate form of support for the patient was discussed.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of their local population and engaged with the NHS England Area Team and local clinical commissioning group (CCG) to secure improvements to services where these were identified. For example, one of the key priorities of the CCG was to reduce the number of smokers in the area, due to a higher than average number of smoking-related deaths. Data from Public Health England showed that the practice had increased their offer of smoking cessation support and treatment from 94% to 97.6% (national average 94.1%) since 2013, and smoking prevalence among the practice population had dropped from 22% in 2013 to 9.3% in 2015 (national average in 2015, 16.4%).

Furthermore, the practice had approached the CCG and other agencies with their own ideas for improvements which could be shared with other services. These included a health and safety risk assessment and pre-placement health/disability questionnaire for medical students which was shared with Health Education England, and will be used by them to assess medical students undertaking placements in general practice.

- The practice had recruited a Patient Services Manager to engage with patients and gather feedback to improve services. They handled all aspects of patient feedback, including investigating and responding to complaints and compliments, monitoring Friends and Family Test and NHS Choices feedback, and managing the patient participation group (PPG).
- The practice offered a 'Commuter's Clinic' on a Tuesday morning from 7am and Wednesday evening until 8.15pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients who needed them, including those with a learning disability.
- Home visits were available for older patients and patients who would benefit from these.
- The practice operated a dedicated telephone line for the care homes and hospitals so that they could access staff directly and did not block the lines for patients trying to make appointments.
- Annual reviews and health checks were carried out at home for patients who found it difficult to travel to the surgery.
- The practice worked with other healthcare providers to improve patient services and increase engagement. For example, the practice co-ordinated some learning disability reviews with a local dentist, so that blood samples for needle phobic patients could be obtained while the patient was under general anaesthetic. This was undertaken with patient and carer consent.
- An acupuncture service was provided by one of the partners. This had reduced referral to secondary care and prescribing of analgesics to patients who used this, with a success rate of approximately 70%.
- The practice had helped a local carers organisation to develop a Do Not Attempt Resuscitation (DNAR) policy, to protect patients and carers.
- Telephone appointments were available for patients who did not need to attend urgently, but who would still benefit from consultation with a doctor or nurse.
- Same day appointments were available, including appointments reserved for children, patients over 75, and those with serious medical conditions.
- A practice nurse with experience of minor illness care had been employed to implement a minor illness clinic at the practice. An evidence-based minor illness list was developed for receptionists, and any patients who fit the criteria on the list could be given an appointment with the nurse instead of a GP. Minor illness appointments were blocked out for these patients. This had reduced the demand for appointments with a GP.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- Staff at the practice had undergone "Dementia Friends" training with the Alzheimer's Society. This encouraged staff to look for ways to make the practice more accessible to patients with dementia.
- There were disabled facilities, a hearing loop and translation services available. Large print letters were used for patients who were visually impaired.
- A local community group raised money for the practice each year. The practice spent the money on products or

services which could be of benefit to the whole community. For example, the money raised last year was used to buy a defibrillator which was available for community use.

- Rooms at the practice were available for use by other services, such as a psychiatrist and a hearing loss charity.
- The practice could offer male and female chaperones.
- The practice was proactive in offering online and text messaging services. These included a service whereby secure online messages could be sent directly to GPs from patients via a patient portal.

Access to the service

People could access services in a way and at a time that suits them. The practice's regular opening hours were between 8am and 6pm Monday to Friday, with extended hours from 7am on Tuesdays and until 8.15pm on Wednesdays. The telephone lines operated at all times during these opening hours. Outside of these times, a message on the surgery phone line directs patients to out of hours care, NHS 111 or 999 emergency services as appropriate. Appointments could also be book online, while GPs could also be contacted directly via an online messaging system.

Appointment times were as follows:

- Monday: 8am-11am and 1.30pm-6pm
- Tuesday: 7am-11am and 1.30pm-6pm
- Wednesday: 8am-11am, 1.30pm-6pm and 6.30pm-8.15pm
- Thursday: 8am-11am and 1.30pm-6pm
- Friday: 8am-11am and 1.30pm-6pm

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was above local and national averages.

- 80.2% of patients were satisfied with the practice's opening hours compared to the CCG average of 76.6% and national average of 74.9%.
- 90.5% patients said they were able to get an appointment to see or speak to someone the last time they tried (CCG average 85.9%, national average 85.2%).
- 80.7% patients said they always or almost always see or speak to the GP they prefer (CCG average 62.1%, national average 60%).

People told us on the day of the inspection that they were able to get appointments when they needed them. We checked the practice's appointment system in real time during our inspection and found that both urgent and routine appointments were available that day. The practice had employed enough staff to able to offer almost double the minimum number of appointments stipulated by their patient list size. The practice also held back appointments for an "overspill" clinic to be used in periods of high demand.

Listening and learning from concerns and complaints

There was an active review of complaints and how they were managed and responded to, and improvements were made as a result. People who used services were involved in the review.

- The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The Patient Services Manager was the designated responsible person who handled all complaints in the practice. Their name and direct contact details were listed in all information regarding patient services, including information on how to make a complaint, and they were available to meet or talk with patients who had concerns.
- We saw that information was available to help patients understand the complaints system. There was a poster in reception, as well as detailed information in the patient leaflet and on the practice website.
- The practice kept a log of compliments as well as complaints, and had received 32 since the practice began recording them in May 2015. Patients who submitted a compliment received a written letter of thanks. Compliments were managed by the Patient Services Manager, and were discussed at team and practice meetings to promote good practice.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

We saw there had been 17 complaints received in the last 12 months, and we found these were satisfactorily handled, dealt with in a timely way, and there had been openness and transparency with dealing with the complaint. The Patient Services Manager handled all complaints, including verbal ones, and also met with patients who had concerns but who did not wish to submit a formal complaint. These concerns were recorded as significant events so that they could be investigated and learning from them could be fed back to relevant teams.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, when a patient complained that the repeat prescription they collected from the surgery had not been signed, meaning they were unable to collect their medication from the pharmacy, the practice implemented a system to ensure prescriptions were checked for signatures when placed in the repeat prescription box and when they were handed to patients.Any which were not signed were returned to a GP for an immediate signature.

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.

- The practice had a mission statement which was displayed in the waiting areas, in the patient leaflet, and on the practice website.
- The practice had identified four key values which were necessary to achieve good outcomes. These were patient-centred care, working together, continuous improvement, and learning. Values were displayed in the practice, patient leaflet and on the website, together with an explanation of what the values meant for staff and patients. Staff we spoke to knew and understood the values and demonstrated them in their work.
- The practice had a detailed strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. The practice had employed managers to lead teams within the practice, as well as giving staff lead roles, which gave the practice manager more time to oversee the overall management of the practice and implement a programme of daily, weekly and monthly meetings to drive improvements.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- There was a programme of continuous clinical and internal audit which was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had comprehensive systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence.
- In 2014 the practice manager designed and implemented a system for reporting and analysing significant events based on the Seven Steps to Patient Safety for Primary Care by the National Patient Safety Agency. This resulted in an increase in reporting, from 11 significant events in 2013 to 54 in 2015. As a result, numerous improvements to practice had been identified and realised.
- The practice evaluated changes made as a result of safety incidents to ensure they were effective.
- Patients were involved in the investigation process, where appropriate. Surveys were conducted to allow patients to suggest ways to improve.

Leaders had an inspiring shared purpose, strove to deliver and motivated staff to succeed. There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular meetings for the whole practice, as well as regular meetings for staff teams.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did. We noted team away days were held every month. Staff had access to the agenda prior to the meeting and could add items they wanted to discuss to this. Minutes were made available to those who could not attend.

Are services well-led?

Outstanding ☆

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

- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. There was a high level of staff satisfaction and staff spoke highly of the culture at the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. Rigorous and constructive challenge from people who used services, the public and stakeholders was welcomed and seen as a vital way of holding services to account.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. They had appointed a Patient Services Manager whose remit was to engage patients and gather and act on feedback. They had created an active PPG which met regularly, as well as a virtual group with around 120 members. The PPG carried out patient surveys and submitted proposals for improvements to the practice management team. For example, patients told the practice that it was difficult for some patients to use the telephone system due to the need to press buttons on the telephone to select different options. As a result this was changed so that if patients did not press any buttons they were put straight through to a receptionist.
- Minutes of PPG meetings and feedback reports were available on the practice website.
- The practice had gathered feedback from staff through annual staff surveys, staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.
- Where feedback was below expectation this was logged as a significant event to allow for a full investigation. For example, on the National GP Patient Survey 69.8% of patients had commented that they found it easy to get through to the practice by telephone, compared to local and national averages of 76.8% and 73.3% respectively. The Patient Services Manager had raised this as a significant event and the reasons for this were being investigated, with input from patients. A survey was developed with the PPG and the practice had received 331 responses. At the time of our inspection the results were to be analysed and an action plan was to be put in place based on the outcome.
- There was a suggestions and comment box in the reception area for patients to give feedback. Information on changes made by the practice as a result of feedback was on display on posters in reception.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. Staff innovation was celebrated, and as a result the practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example:

- Continuous improvement and learning were highlighted as two of the practice's key values. There was a culture within the practice of identifying opportunities for learning. All staff understood the importance of identifying and reporting anything that could lead to improvement as a significant event. This was a key part of staff induction, and all staff we spoke to understood their role in driving improvement.
- The practice had employed staff to perform specific roles which they had identified as being key to improving practice. This included employing practice nurses with experience of minor illness management and respiratory care to lead minor illness clinics and asthma and COPD care pathways respectively. They had also employed a pharmacist who had been involved in the Shine project to reduce unnecessary prescribing to implement the project in the care homes where the practice had patients.
- The practice had developed their own apprenticeship programme for administration staff. Staff from the programme had remained with the practice and developed into other roles, such as healthcare assistant.
- The practice had been proactive in implementing the CCG-led High Risk Register. This had resulted in a reduction of unplanned admissions from 239 in 2013/14 to 99 in 2015/16.

Are services well-led?

Outstanding ☆

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

- Results and feedback from clinical appraisals were shared with other staff in monthly clinical education meetings to share any good practice identified. Outside speakers were also often invited to these sessions.
- Where results for Quality and Outcomes Framework were below local or national averages a significant event was logged. This allowed the whole practice team, both clinical and administrative, to be involved in the investigation and to look for ways to improve.
- Good practice was shared with external agencies. The Shine project was now being adopted by the CCG, and risk assessments developed at the practice were being used by Health Education England.