West Road Medical Centre

Quality Report

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

Ratings

Overall rating for this service	**Outstanding** ☆
Are services safe?	**Good** ●
Are services effective?	**Outstanding** ☆
Are services caring?	**Good** ●
Are services responsive to people's needs?	**Outstanding** ☆
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 a planned comprehensive inspection of West Road Medical Centre on 10 December 2014.

Overall, we rated the practice as outstanding.

Our key findings were as follows:

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

We saw the following areas of outstanding practice:

- One of the GPs worked with a local charity (HAREF, the Health and Race Equality Forum) and the Newcastle Diabetes Centre to make sure health promotion information was made available to patients within ethnic minority communities.
- Highly effective systems were in place to manage patients' long term conditions. Nationally reported guidance showed the practice was performing well above local and national averages in relation to the management of long term conditions.
- The practice had strong links with local communities and services had been designed to reflect the needs of the diverse population served by the practice. Staff were aware of patients' religious beliefs and adapted their approach accordingly.
- The practice worked with female patients within migrant communities to promote the cervical screening service. Staff told us there had been an increase in the uptake of screening tests following this.

Summary of findings

- Patient feedback was very positive; results from the National Patient Survey showed the practice was performing well. For example, 97% of patients were satisfied with opening hours (compared to 77% nationally).

However, there was also an area of practice where the provider should make improvements.

The practice should:

- maintain clear records on prescription stationery stock, in line with guidance from NHS Protect.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated to improve the quality of the service. Information about safety was recorded, monitored, appropriately reviewed and addressed. We confirmed there were adequate staffing levels and a good mix of skills in the team. The practice was clean and infection control well managed. There were systems in place to manage medicines, although there were no arrangements to monitor the receipt and distribution of blank prescription pads.

Are services effective?

Outstanding

The practice is rated as outstanding for effective. Data showed that the practice was performing highly when compared to neighbouring practices in the CCG. The practice was innovative and linked with local charities and organisations to meet the diverse needs of its patients. The practice was proactive in the management, monitoring and improving of outcomes for patients. For example, one of the GPs worked with a local charity (HAREF, the Health and Race Equality Forum) and the Newcastle Diabetes Centre to make sure information about preventing and managing diabetes was made available to patients within ethnic minority communities. Highly effective systems were in place to manage patients' long term conditions. Nationally reported guidance showed the practice was performing well above local and national averages in relation to the management of long term conditions.

Are services caring?

Good

The practice is rated as good for caring. Patients we spoke with and those who completed CQC comment cards were complimentary about the practice. They said they were treated with dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We found there was a patient-centred culture and staff treated patients with kindness and compassion. Staff we spoke with were aware of the importance of maintaining patient confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for responsive. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. The practice had strong links with the local community and the services had been designed

Summary of findings

to reflect the needs of the diverse population. Patients reported good access, a named GP and continuity of care. Urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision which was shared by all staff. There was an effective governance framework in place, which focused on the delivery of high quality care. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients and had a very active patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered personalised care to meet the needs of the older people in its population. The practice had written to patients over the age of 75 years to inform them who their named GP was. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of people with long-term conditions. Highly effective systems were in place to monitor patients within long term conditions. The practice was proactive in addressing health needs relating to some additional long term conditions, which were not nationally monitored, but were prevalent within the local community. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. Patients had reviews to check their health and medication needs were being met. The practice aimed to complete reviews for patients with more than one long term condition at the same appointment; reducing the need for patients to attend on multiple occasions. For those people with the most complex needs the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Outstanding

The practice is rated as outstanding for the care of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age appropriate way and recognised as individuals. A practice information leaflet for young adults had been produced and staff visited local schools to talk about the services available. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice had worked with the CCG to provide a drop in service for young people and we were provided with good examples of joint working with midwives and health visitors.

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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). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. We saw examples where the practice worked with the local community and reached out to specific groups of working age people to inform them about specific health conditions and how the practice could support them. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Outstanding ☆

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

The staff knew all the practice patients well and were able to identify a person in crisis. We saw examples whereby patients in vulnerable circumstances had been identified and saw how staff had intervened to provide help, arranged appointments and worked in close partnership with other health and social care professionals to assist the patients.

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

People experiencing poor mental health (including people with dementia)

Good ●

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had care planning in place for patients with dementia.

Summary of findings

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

Summary of findings

What people who use the service say

We spoke with 10 patients during our inspection. We spoke with people from different age groups, who had varying levels of contact and had been registered with the practice for different lengths of time.

We reviewed 12 CQC comment cards which had been completed by patients prior to our inspection.

All were complimentary about the practice, staff who worked there and the quality of service and care provided. They told us the staff who worked there were very caring and helpful. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were generally happy with the appointments system.

The latest GP Patient Survey completed in 2014 showed the large majority of patients were satisfied with the services the practice offered. The results were among the best for GP practices nationally. The results were:

- The proportion of patients who would recommend their GP surgery – 79% (national average 78%)
- GP Patient Survey score for opening hours – 97% (national average 77%)
- Percentage of patients rating their ability to get through on the phone as very easy or easy – 91% (national average 73%)
- Percentage of patients rating their experience of making an appointment as good or very good – 78% (national average 75%)
- Percentage of patients rating their practice as good or very good – 90% (national average 86%).

Areas for improvement

Action the service SHOULD take to improve

The practice should ensure that robust arrangements are in place to record and monitor the receipt and distribution of blank prescription forms.

Outstanding practice

The practice was considered to be outstanding in terms of their effectiveness. The practice was proactive in the management, monitoring and improving of outcomes for patients. For example, one of the GPs worked with a local charity (HAREF, the Health and Race Equality Forum) and the Newcastle Diabetes Centre to make sure information about preventing and managing diabetes was made available to patients within ethnic minority communities. The practice had identified that a specific group of male patients (taxi drivers from south Asian communities) were hard to reach. They worked in partnership with HAREF to produce another information leaflet about diabetes, specifically for this group of patients. The leaflet was distributed via the Newcastle British Bangladeshi Taxi Union and contained within the practice's own newsletter

Effective systems were in place to manage patients' long term conditions. Nationally reported guidance showed the practice was performing well above local and national averages in relation to the management of long term conditions.

The practice was considered to be outstanding in terms of their responsiveness. Staff had strong links with local communities and services had been designed to reflect the needs of the diverse population served by the practice. For example, staff were aware of patients' religious beliefs and adapted their approach accordingly. Appointments for blood tests were scheduled to take account of religious events such as Ramadan (this is a time when Muslims across the world will fast during the hours of daylight). One of the GPs told us how the

Summary of findings

practice worked with religious leaders to ensure a type of medication would be suitable and to promote the usage of Vitamin D for women within the Bangladeshi community.

Strong links with local charities and religious organisations had been developed to ensure the needs of patients within ethnic minority groups were addressed.

One such area was reaching out to female patients within migrant communities to promote the cervical screening service. Staff told us there had been an increase in the uptake of screening tests following this.

Patient feedback was very positive; results from the National Patient Survey showed the practice was performing well. For example, 97% of patients were satisfied with opening hours (compared to 77% nationally).

West Road Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team also included a GP and a specialist advisor with experience of GP practice management.

Background to West Road Medical Centre

West Road Medical Centre is registered with the Care Quality Commission to provide primary care services. It is located in the Fenham area of Newcastle upon Tyne.

The practice provides services to around 9,200 patients from one location; 170 West Road, Newcastle upon Tyne, NE4 9QB. We visited this address as part of the inspection. The practice has six GP partners, a nurse practitioner partner, two practice nurses, a healthcare assistant, a practice manager, and 16 staff who carry out reception and administrative duties.

The practice is part of Newcastle West Clinical Commissioning Group (CCG). The practice is situated in an area of high deprivation. The practice population is made up of a higher than average proportion of patients under the age of 35 and a lower than average proportion of patients over the age 35.

The practice is located in a two storey building; patient facilities are situated on both the ground and first floor. It also offers a disabled WC, wheelchair and step-free access.

Surgery opening times at the practice are between 8:30am and 6:00pm Monday to Friday. The practice is also open one Saturday each month from 9:00am to 2:00pm. Patients can book appointments in person, on-line or by telephone.

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 Northern Doctors.

The CQC intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

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 10 December 2014. We spoke with ten patients and 12 members of staff from the practice. We spoke with and interviewed four GPs, the practice manager, three members of the nursing team and four staff carrying out reception and administrative duties. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 11 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe track record

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. Information from the QOF, which is a national performance measurement tool, showed significant events were appropriately identified and reported.

The practice used a range of information to identify risks and improve patient safety. These included complaints, findings from clinical audits, significant events and feedback from patients and other health and social care professionals. Staff were clear about their responsibilities in reporting any safety incidents.

There were clear lines of leadership and accountability in respect of how significant incidents were investigated and managed. GPs told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development. Staff we spoke with were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety.

We looked at some records of significant events which had been reported and the subsequent actions taken. For example, a recent incident had been recorded in relation to a home visit. This had resulted in a change of practice. Our observations during the inspection showed this had been put into practice.

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

Learning and improvement from safety incidents

The practice was open and transparent when there were near misses or when things went wrong. There was a system in place for reporting, recording and monitoring significant events, incidents and accidents.

When incidents occurred the practice had systems in place to ensure there was effective learning in order to minimise the likelihood of such events recurring. There were effective protocols in use to scrutinise practice. We saw records of significant events that had occurred during the last 12 months. We found details of the event, steps taken, specific action required and learning outcomes and action points were noted. We saw they were discussed at monthly practice meetings which all clinical and non-clinical staff attended. For instance, a small number of patients had not been informed about some test results, this was discussed at a clinical meeting and plans were put into place to minimise future risk.

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.

We discussed the process for dealing with safety alerts with the practice manager. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. They told us alerts came into the practice from a number of sources, including the General Medical Council (GMC) and the local clinical commissioning group (CCG). Any alerts were reviewed by one of the GP partners and the practice manager, information was then disseminated to relevant members of staff. The practice manager was able to give examples of recent alerts and how these had been responded to. A record had been kept to indicate when alerts had been reviewed. We were told where safety alerts affected the day-to-day running of the practice; all staff would be advised via an email or in a practice meeting.

Reliable safety systems and processes including safeguarding

The practice had systems in place to protect and safeguard children and vulnerable adults. There were detailed safeguarding policies which provided staff with information about safeguarding legislation and how to identify, report and deal with suspected abuse.

The practice had a named lead GP in safeguarding vulnerable adults and children. The clinicians discussed ongoing and new safeguarding issues at their weekly meeting, and also held meetings with health visitors every six weeks.

We saw records which confirmed all staff had attended training on safeguarding children and adults. The GPs had received the higher level of training for safeguarding

children (Level 3). Other clinical staff had received Level 2, whilst all other staff attended Level 1 training sessions. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. We saw evidence that recent concerns regarding the safeguarding of a child were promptly passed on to the relevant authorities by staff.

The computer software used by the practice meant staff entered codes which then flagged up where a patient (child or adult) was vulnerable or required additional support, for instance if they were a carer. 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 A&E.

The practice had a chaperone policy. We saw posters on display in the waiting room to inform patients of their right to request a chaperone. Staff told us that a practice nurse or a member of the administration team undertook this role. Staff had received appropriate training and were clear about the requirements of the role.

A whistleblowing policy was in place. Staff we spoke with were all able to explain how, and to who, they would report any such concerns. They were all confident that concerns would be acted upon.

Medicines management

There were clear systems in place to manage medicines. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. We saw medicines were in date and good systems to check expiry dates were implemented. There were procedures to ensure expired and unwanted medicines were disposed of in line with waste regulations.

There was a clear policy for ensuring medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Staff confirmed the procedure to check the refrigerator temperature every day and ensure the vaccines were stored at the correct temperature. The staff showed us their daily records of the temperature recordings, we saw the correct temperature for storage was maintained.

Each of the GPs had a 'doctor's bag' containing medicines for use during home visits. Comprehensive systems were in place to ensure these medicines were in date. The GPs were each responsible for the contents of their own bag; the healthcare assistant also carried out monthly checks. We looked at the medicines in one doctor's bag, all of the medicines were in date.

There were systems in place to ensure GPs regularly monitored patients medicines and re issuing of medicines was closely monitored, with patients invited to book a 'medication review', where required. The practice employed a part time pharmacist to monitor medicines and ensure the prescribing of medicines was safe. This was to confirm the practice operated in line with national NHS guidelines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw records of blank prescription form serial numbers were not made on receipt into the practice or when the forms were issued to GPs. This is contrary to guidance issued by NHS Protect, which states that 'organisations should maintain clear and unambiguous records on prescription stationery stock'.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. For example, how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. The practice was working with a local pharmacy to improve the arrangements for sending repeat prescriptions to the pharmacy for patients to collect. This involved prescriptions being processed a week in advance, once authorised they were then collected by the pharmacist in batches. The pharmacy and practice staff felt this worked well and streamlined the process.

Cleanliness and infection control

We looked around the practice and saw it was clean, tidy and well maintained. Suitable arrangements had been made which ensured the practice was cleaned to a satisfactory standard. 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. Comments from patients who completed CQC comment cards reflected this.

One of the practice nurses was the nominated infection control lead. We saw there was an up to date infection control policy and detailed guidance for staff about specific issues. For example, action to take in the event of a

Good

Are services safe?

spillage. All of the staff we spoke with about infection control said they knew how to access the practice's infection control policies. Infection control training was provided for all staff annually.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. The privacy curtains in the consultation rooms were changed every six months or more frequent if necessary. We saw the curtains were clearly labelled to show when they were due to be replaced.

The practice had a needle stick injury policy in place, which outlined what staff should do and who to contact if they suffered this injury. We saw appropriate sharps receptacles in place in the treatment rooms. Separate containers were provided for the disposal of contaminated sharps such as used needles. Staff told us they ensured spillage kits were available to clean areas contaminated with body fluids.

Staff were protected against the risk of health related infections during their work. We asked the reception staff about the procedures for accepting specimens of urine from patients. They showed us there was a box for patients to put their own specimens in. The nursing staff then wore PPE when emptying the box and transferring the specimens. We confirmed with the practice manager that all clinical staff had up to date hepatitis B vaccinations. The practice carried out regular checks of the water system for legionella (a type of bacteria found in the environment which can contaminate water systems in buildings). The practice had suitable and sufficient risk assessments required to identify and assess the risk of exposure to legionella bacteria from work activities. Water systems on the premises were checked to ensure continued safety.

Equipment

The practice had appropriate equipment for managing emergencies. Emergency equipment included a defibrillator and oxygen. These were readily available for use in a medical emergency and were checked each day to ensure they were in working condition. Resuscitation equipment and medication was easily accessible.

A log of maintenance of clinical and emergency equipment was in place and staff recorded when any items identified as faulty were repaired or replaced.

We saw the practice had annual contracts in place for portable appliance tests (PAT) and also for the routine servicing and calibration, where needed, of medical equipment.

Staffing and recruitment

We saw the practice had an up to date recruitment policy in place that covered all aspects of the recruitment of staff. We looked at a sample of two personnel files. We saw that pre-employment checks, such as obtaining a full work history, evidence of identity and references had been carried out, prior to staff starting work.

The practice manager and all staff that were in contact with patients had been subject to Disclosure and Barring Service (DBS) checks, in line with the recruitment policy.

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) each year to make sure they were still deemed fit to practice. We saw records which confirmed these checks had been carried out.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff 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 answering the telephones.

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the

Good

Are services safe?

building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff and patients to see and there was an identified health and safety lead.

The practice manager showed us a number of risk assessments which had been developed and undertaken; including a fire and a health and safety risk assessment. Risk assessments of this type helped to ensure the practice was aware of any potential risks to patients, staff and visitors and planned mitigating action to reduce the probability of harm.

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

.

Arrangements to deal with emergencies and major incidents

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

Emergency medicines were available in a secure area of the practice and all staff knew of their location. A resuscitation trolley was located in the main treatment room. There was a good selection of paediatric and adult masks and airways. Intravenous cannulation was available with a variety of venflons (a small tube that can be inserted into a body cavity, duct, or vessel) and all were in date. There was a laminated sheet that clearly listed the contents of the trolley and this corresponded to the medicines available. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather and access to the building. Copies of the plans were held by the practice manager and GPs at their homes so contact details were available if the building was not accessible. The practice manager told us the computer system used by the practice could also be securely accessed off site if necessary.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could outline the rationale for their treatment approaches. They were familiar with current best practice guidance, and were able to access guidelines from the National Institute for Health and Care Excellence (NICE) via the practice IT system.

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

The practice had a holistic approach to assessing, planning and delivering care and treatment. Nearly a third of patients registered with the practice had a long term condition. Many of those patients had multiple conditions so the practice had developed a detailed plan for organising care. The practice was proactive in addressing health needs relating to some additional long term conditions, which were not nationally monitored, but were prevalent within the local community.

Appointments were made available where patients could have reviews of all conditions, rather than a separate appointment for each one. This was more convenient for patients but also enabled the clinical staff to have an overall picture of patients' health. One of the administrative team members worked with the clinicians to organise the reviews. A system was in place to ensure patients were recalled when appropriate. A detailed week by week plan was maintained by the administrative lead. There was specific guidance for staff about contacting patients who had not responded to initial invites to make appointments. For example, a follow-up letter would be sent out. If this was unsuccessful then staff would telephone patients to invite them in. Nationally reported data showed the practice was performing well above local and national averages in relation to the management of long term conditions.

The GPs told us they led in specialist clinical areas such as asthma, sexual health and diabetes. We saw regular educational sessions were arranged by the relevant GP leads. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

We were told patient safety alerts and guidelines from NICE were discussed at relevant team meetings to enable shared learning. We saw minutes of practice meetings where new guidelines were shared with staff, the implications for the practice's performance were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure each patient received support to achieve the best health outcome for them.

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

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

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles, which led to improvements in clinical care. Audits were carried out for various reasons, including for GP appraisal purposes, medicines management and to assess how well the practice was performing. We saw a number of clinical audits had recently been carried out. The results and any necessary actions were discussed at the clinical team meetings.

Examples of clinical audits included an audit on foot care for patients with diabetes. This demonstrated that the proportion of diabetic patients that had received a foot examination was below the national target. The practice changed the system for contacting patients and recording arrangements. A re-audit showed an improvement in the percentage of patients who had a foot examination, from 70.4% to 82.9%. We saw plans were in place to repeat the audit again in 12 months' time

The practice had also carried out an audit on how patients fitted with an intra-uterine device (IUD, a type of contraception) were recalled. We found the practice had

responded to the issues identified and had updated the system for recording when patients were due to be recalled. This audit had only recently been undertaken and we saw plans were in place to repeat the audit after six months to assess the effectiveness of the revised procedures.

Staff supported people to live healthier lives through a targeted and proactive approach to health promotion and the prevention of ill health. A number of examples were provided by the GPs we spoke with to support this. For example, one of the GPs worked with a local charity (HAREF, the Health Improvement Service for Ethnic Minorities) and the Newcastle Diabetes Centre to make sure information about preventing and managing diabetes was made available to patients within ethnic minority communities. This included the production and circulation of an information leaflet about diabetes to all local mosques and the Hindu Temple. The GP had identified that a specific group of male patients (taxi drivers from south Asian communities) were hard to reach. They worked in partnership with HAREF to produce another information leaflet about diabetes, specifically for this group of patients. The leaflet was distributed via the Newcastle British Bangladeshi Taxi Union and contained within the practice's own newsletter.

Staff were proactive in the management, monitoring and improving of outcomes for patients. The practice also used the information they collected for the Quality and Outcomes Framework (QOF), which is a national performance measurement tool, and their performance against national screening programmes to monitor outcomes for patients. The practice had achieved 98.0% of the points available for clinical results; this was above the national and local averages (92.3% and 95.5% respectively). The practice was not an outlier for any QOF clinical targets.

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. For example, a higher proportion of patients over the age of 65 (82%) had received the seasonal vaccination compared to the national average (73%).

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. Once a month the practice closed for an afternoon for Protected Learning Time (PLT). Some of the time during these afternoons was dedicated to training. Training was also delivered by external experts, for example, a representative from the Local Authority provided some training on how to recognise signs of domestic violence.

The continuing development of staff skills and competence was recognised as integral to ensuring high quality care. Role specific training was provided. The practice nurses had been trained to administer vaccines and had attended updates on cervical screening. All of the clinical staff had attended a training course on anaphylaxis to increase their skills and knowledge in that area. The practice provided staff with equality and diversity training. Staff were proactively supported to acquire new skills and share best practice. For example, one GP was being supported to undertake a degree in education. This would lead to them being able to support new GPs within the practice in their training.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with NHS England).

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.

The practice had a comprehensive approach to the induction of new staff. We saw all new staff, from GPs to receptionists were provided with an induction pack and received a formal induction to the practice. This was monitored by the practice manager and provided new staff with opportunities to learn about the practice and their own specific role. Staff were encouraged to take the time reflect on what they had learned and regular reviews took place throughout the induction period.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The patients we spoke with were complimentary about the staff. Staff we spoke with and observed were knowledgeable about the role they undertook.

Working with colleagues and other services

The practice worked closely with other health and social care providers, to co-ordinate care and meet people's needs. The practice was a member of a group of GP practices located in the West of Newcastle who met regularly to build relationships and share learning with the aim of improving patient care. The practice team felt this had been beneficial for both themselves and their patients.

We saw various multi-disciplinary meetings were held. For example, a weekly clinical team meeting was held, this included GPs, nurses and the district nursing team. Child protection and palliative care review meetings were held every six weeks. There were well established links with local Macmillan nurses. This helped to share important information about patients including those who were most vulnerable and high risk.

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.

Information sharing

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

Blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service, were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP who reviewed these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. Training had been delivered to all staff by the local NHS Trust. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the MCA 2005. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment.

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 'new patient check'. The initial appointment was scheduled with one of the Healthcare Assistants, to ascertain details of their past medical histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

smoking, alcohol intake, blood pressure, height and weight). The patient was then 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 area of the practice. This included information about screening services, smoking cessation and child health. The practice had a proactive approach to support people to live healthier lives. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. The practice worked with a local sports centre to promote exercise on prescription for patients. There was also a specific sports and fitness service where patients who did not speak English could be referred to. The practice's website also provided some further information and links for patients on health promotion and prevention.

We found patients with long term conditions were recalled to check on their health and review their medications for effectiveness. The practice's electronic system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively. We were told this worked well to prevent any patient groups from being overlooked. Processes were in place to ensure the regular screening of patients was completed, for example, cervical screening.

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

The practice offered a full range of immunisations for children, as well as travel and flu vaccinations, in line with current national guidance. MMR vaccination rates for five year old children were 98.5% compared to an average of 92.7% in the local CCG area. The percentage of patients in the 'influenza clinical risk group', who had received a seasonal flu vaccination was in line with the national average.

The practice also worked with a local public health organisation (Health Improvement Service for Ethnic Minorities, HISEM) to encourage patients to access health information and services. One such area was reaching out to female patients within migrant communities to promote the cervical screening service. Staff told us there had been an increase in the uptake of screening tests following this. Nationally reported data showed that the 80% of those eligible had received a test within the past five years. This was in line with the national average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with ten patients during our inspection. They were all happy with the care they received. People told us they were treated with respect and were positive about the staff. Comments left by patients on the 11 CQC comment cards we received also reflected this. Words used to describe the approach of staff included caring, professional, supportive, patient and kind.

We looked at data from the National GP Patient Survey, published in July 2014. This demonstrated that patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. We saw that 90% (compared to 86% nationally) of patients said they had confidence and trust in their GP and 85% (compared to 83% 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 on the CQC comment cards referred to the helpful nature of the reception staff in particular. This was reflective of the results from the National GP Survey where 95% of patients felt the reception staff were helpful, compared to a national average of 88%.

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

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

Staff were familiar with the steps they needed to take to protect people's 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 83% of practice respondents said the GP was good at involving them in care decisions and 88% felt the GP was good at explaining treatment and results. Both these results were in line with the CCG area and national averages.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the 11 CQC comment cards we received was also positive and supported these views. One person commented that they were listened to and their problem was dealt with. Another said all tests and procedures were fully explained to them.

We saw that access to interpreting services was available to patients, should they require it. The practice had a high proportion of patients who did not speak English as their first language. 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.

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 people's wishes at these times.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were tailored to meet the needs of individuals. The practice 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 provided a range of services and clinics 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. 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.

Patients were able to access services in a way that suited them. Longer appointments were made available for people who needed them and 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 from 2014 confirmed this. 92% of patients felt the doctor gave them enough time, 85% felt they had sufficient time with the nurse. These results were well above the national averages (86% and 81% respectively).

The practice engaged regularly with the Clinical Commissioning Group (CCG) to discuss local needs and service improvements that needed to be prioritised. We saw where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, offering drop in services for young people and attending local schools to inform children about the services offered by the practice.

The involvement of other organisations was integral to how services were planned. The practice worked with two other local GP practices and had formed a social enterprise (West End Family). One of the GPs told us these practices were working together to deliver better health care and improved access for patients.

The practice had a well-established Patient Participation Group (PPG). We spoke with two 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 instance they had listened to and acted on suggestions about the redecoration of the premises.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, opening times had been extended and the practice was open on one Saturday each month. This helped to improve access for those patients who worked full time.

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 whose first language was not English. One of the GPs spoke three different languages and the touch screen check in system in the reception area was available to access in 12 different languages. Another of the GPs had met with women from a local minority group to explain about the services provided by the practice. This included advice on contraception and support services available.

Staff were aware of patients' religious beliefs and adapted their approach accordingly. Appointments for blood tests were scheduled to take account of religious events such as Ramadan (this is a time when Muslims across the world will fast during the hours of daylight). One of the GPs told us how the practice worked with religious leaders to ensure a type of medication would be suitable and to promote the usage of Vitamin D for women within the Bangladeshi community.

The practice also worked with a local public health organisation (Health Improvement Service for Ethnic Minorities, HISEM) to encourage patients to access health information and services. One such area was reaching out to female patients within migrant communities to promote the cervical screening service. Staff told us there had been

an increase in the uptake of screening tests following this. Nationally reported data showed that the 80% of those eligible had received a test within the past five years. This was in line with the national average.

One of the GPs had forged close links with groups of patients who had negative opinions about health services. They spent time getting to know families and gained the trust of the patients. The practice was flexible when arranging appointment with this group of patients to encourage them to use the services. Staff told us how over time the group of patients were accepting of the support provided by the practice and they continued to build on the relationships.

The premises and services had been adapted to meet the needs of people with disabilities. The main entrance and internal doors had been automated to improve access and there were treatment and consulting rooms on the ground floor which could be accessed by those with mobility difficulties. The patient toilet could be accessed by patients with disabilities. A portable induction loop system was available for patients who experienced difficulties with their hearing.

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

Access to the service

The practice was open between 8:30am and 6:00pm Monday to Friday. Weekend appointments were available one Saturday per month between 9:00am and 2:00pm. Evening surgeries had been tested for a time but patient feedback suggested these were not beneficial as many did not like to go out during the dark nights. All patients were seen on the same day if their need was urgent. On the day of our inspection we were told the current average time to wait for a routine appointment with a GP was four days.

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

All of the patients we spoke with, and those who filled out CQC comment cards, said they were satisfied with the appointment systems operated by the practice. Many people commented they were able to get an appointment or speak to a clinician at short notice. This was reflected in the results of the most recent National GP Patient Survey (2014). This showed 78% of respondents were satisfied with booking an appointment and 97% were satisfied with the opening hours. These results were 'among the best' for GP practices nationally.

Staff told us they carried out continual monitoring of the appointments system and were always considering how it could be further improved. Following a recent review, changes had been made to the telephone system and the arrangements for home visits. The number of home visits was increased and they were spread across the whole day, rather than at specific times to improve flexibility for the patients and clinicians.

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

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 the practice's website. The practice also had a comments box situated in the entrance foyer to enable patients to provide feedback about the service provided.

None of the eight patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice. In addition, none of the 12 CQC comment cards completed by patients indicated they had felt the need to make a complaint.

We saw the summary of complaints that had been received in the 12 months prior to our inspection. We found these

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

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. For instance, as a result of one formal complaint, all staff had received further training on equality and diversity.

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. This was documented within the practice's statement of purpose. It was evident in discussions we had with staff throughout the day that it was a shared vision and was fully embedded.

The strategy had been developed during a practice away day and all staff had input to the overall vision. A further development session was planned for early 2015.

We spoke with 12 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.

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 minutes showed what actions needed to be taken and who was responsible.

The practice used the Quality and Outcomes Framework (QOF) as an aid to measure their performance. The QOF data for this practice showed it was performing above the averages of the local Clinical Commissioning Group (CCG) and across England as a whole. Performance in these areas was monitored by the practice manager and GPs, supported by the administrative staff. We saw that QOF data was discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice had completed a number of clinical and internal audits, including a review of infection control and health and safety arrangements. 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 a GP partner was the lead for health and safety and contraception. We spoke with 12 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 concerns and suggestions for improvement.

We found the practice leadership proactively drove continuous improvement and staff were accountable for delivering this. There was a clear and proactive approach to seeking out and embedding new ways of providing care and treatment. Examples included work completed on reducing the number of unnecessary admissions to hospitals and changes to the telephone system to improve access.

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

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

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions on a daily basis. Staff we spoke with told us they regularly attended staff meetings. They said these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We saw the practice also used the meetings to share information about any changes or action they were taking to improve the service and they actively encouraged staff to discuss these points. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had an active patient participation group (PPG). The PPG contained representatives from various population groups and was actively trying to increase representation from the younger population. In the past the group had conducted a survey of younger patients in an attempt to try and engage with them. The PPG met regularly and a representative from the practice always

Are services well-led?

Good

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

attended to support the group. We spoke with some members of the group and they felt the practice supported them fully with their work and took on board and reacted to any concerns they raised.

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.

We saw a practice newsletter was produced every other month. This contained a wealth of information about the practice, the staff and any changes which affected patients. For example, one newsletter included details of revisions to the telephone system; another referred to opening hours over the Christmas period. The most recent newsletter contained the results from a recent patient survey and the actions taken by the practice to address patient concerns.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the policy, how to access it and said they wouldn't hesitate to raise any concerns they had.

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 saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and development opportunities.

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

The practice manager met regularly with other practice managers in the area and shared learning and experiences from these meetings with colleagues. This included the development of a community forum to link local services and the CCG. GPs met with colleagues at locality and CCG meetings. They also attended learning events and shared information from these with the other GPs in the practice. For example, one of the GPs had worked with CCG to introduce drop-in sessions for young people.