# Walker Medical Group

## Quality Report

Walker Centre
Church Walk
Walker
Newcastle upon Tyne
NE6 3BS
Tel: 0191 262 0444
Website: www.walkermedical.nhs.net

Date of inspection visit: 12 February 2015
Date of publication: 29/10/2015

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

## Ratings

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

# Summary of findings

## Contents


### Summary of this inspection

Page

Overall summary 2
The five questions we ask and what we found 4
The six population groups and what we found 6
What people who use the service say 9
Areas for improvement 9
Outstanding practice 9

### Detailed findings from this inspection

Our inspection team 10
Background to Walker Medical Group 10
Why we carried out this inspection 10
How we carried out this inspection 10
Detailed findings 12


## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out a comprehensive announced inspection at Walker Medical Group on 12 February 2015. Overall, the practice is rated as good. Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led services. It was also good at providing services for five of the six key population groups we looked at during the inspection. We found the practice to be outstanding for providing responsive services to families, children and young people.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed;
- Risks to patients were assessed and well managed;
- The practice was clean and hygienic, and good infection control arrangements were in place;
- Patients' needs were assessed and care was planned and delivered following best practice guidance;
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment;
- Information about the services provided by the practice was available and easy to understand, as was information about how to raise a complaint;
- The practice had good facilities and was well equipped to treat patients and meet their needs;
- There was a clear leadership structure and the practice had good governance arrangements. The practice actively sought feedback from patients.

We saw areas of outstanding practice:

- The practice is recognised by the Royal College of General Practitioners as a youth friendly practice. To achieve this, the practice had to demonstrate that they had developed services for younger patients by, for example, improving access and encouraging young

# Summary of findings

patients to be actively involved in their care. The practice safeguarding lead had visited a local school and spoke with young people about confidentiality and how they could access the practice.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for providing safe services.

The nationally reported data we looked at as part of our preparation for this inspection did not identify any concerns relating to safety. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The GP partners and practice management team took action to ensure lessons were learned from any incidents or concerns, and shared these with staff to support improvement. Overall, there was evidence of good medicines management. However, when carrying out routine home visits, GPs did not always take a range of drugs with them for use in acute situations. Good infection control arrangements were in place and the practice was clean and hygienic. Safe staff recruitment practices were followed and there were enough staff to keep patients safe.

**Are services effective?**

Good

The practice is rated as good for providing effective services.

The nationally reported data we looked at as part of our preparation for this inspection did not identify any concerns relating to the provision of effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE), and the local Clinical Commissioning Group (CCG). Staff had received training appropriate to their roles and responsibilities. The practice had made appropriate arrangements to support clinical staff with their continuing professional development. There were systems in place to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment.

**Are services caring?**

Good

The practice is rated as good for providing caring services.

Nationally reported data showed patient outcomes were mostly either in line with, or better than the local CCG and national averages. Patients said they were treated well and were involved in making decisions about their care and treatment. Arrangements had been made to ensure their privacy and dignity was respected.

# Summary of findings

Patients had access to information and advice on health promotion, and they received support to manage their own health and wellbeing. Staff demonstrated they understood the support patients needed to cope with their care and treatment.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services.

Nationally reported data showed patient outcomes were either in line with, or better than the local CCG and national averages. Findings from the National GP Patient Survey of the practice, published in January 2015, showed most patients were satisfied with practice opening hours, telephone access, and appointment availability. For example, of patients who responded to the survey, 93% said they were satisfied with the practice's opening hours. This was above the local CCG average of 82% and the national average of 76%. However, some of the patients we spoke to on the day of our inspection said they experienced difficulties getting through to the practice and obtaining an appointment. Evidence obtained during the inspection demonstrated the practice was actively taking steps to provide better access to appointments. This included, for example, exploring how they could reduce the number of occasions when patients failed to attend appointments.

Services had been planned to meet the needs of the key population groups using the practice. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints procedure, with evidence demonstrating the practice made every effort to address any concerns raised with them.

**Are services well-led?**

Good

The practice is rated as good for providing well led services.

The leadership, management and governance of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision for improving the service and promoting good patient outcomes. An effective governance framework was in place. Staff were clear about their roles and understood what they were accountable for. The practice had a range of policies and procedures covering its activities. Systems were in place to monitor and, where relevant, improve the quality of the services provided to patients. The practice actively sought feedback from patients and used this to improve the services they provided.

# 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 patients.

Nationally reported Quality and Outcome Framework (QOF) data for 2013/14 showed the practice had achieved good outcomes in relation to the conditions commonly associated with older people. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with heart failure. This was 4.1 percentage points above the local Clinical Commissioning Group (CCG) average and 2.9 points above the England average.

The practice provided proactive, personalised care to meet the needs of older people. They provided a range of enhanced services including, for example, allocating a named GP who was responsible for overseeing the care and treatment received by the practice's older patients. Clinical staff had received the training they needed to provide good outcomes for older patients. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those who needed this.

**People with long term conditions**

Good

The practice is rated as good for the care of patients with long-term conditions.

Nationally reported QOF data for 2013/14 showed the practice had achieved good outcomes in relation to the conditions commonly associated with this population group. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with chronic obstructive pulmonary disease (COPD). This was 5.5 percentage points above the local CCG average and 4.8 points above the England average.

The practice had taken steps to reduce unplanned hospital admissions by improving services for patients with complex healthcare conditions. All patients on the practice's long-term conditions registers received healthcare reviews that reflected the severity and complexity of their needs. Clinical staff had the training they needed to provide good outcomes for patients with long-term conditions.

**Families, children and young people**

Outstanding

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

# Summary of findings

Nationally reported QOF data for 2013/14 showed the practice had achieved 100% of the total points available to them for providing maternity services and child health surveillance. These achievements were above the England averages (i.e. 0.9 and 1.2 percentage points above respectively) and in line with the local CCG averages.

Systems were in place for identifying and following-up children who were considered to be at risk of harm or neglect. Where comparisons allowed, we found the delivery of childhood immunisations was higher when compared with the overall percentages of children receiving the same immunisations within the local CCG area. For example, rates for seven of the eight childhood immunisations given to children aged five years were above the local CCG averages. New mothers had access to regular baby clinics, and ante-natal appointments were offered by healthcare professionals attached to the practice. Appointments were available outside of school hours and the premises were suitable for children and babies.

The practice is recognised by the Royal College of General Practitioners as a youth friendly practice. To achieve this, the practice had to demonstrate that they had developed services for younger patients by, for example, improving access and encouraging young patients to be actively involved in their care. The practice safeguarding lead had visited a local school and spoke with young people about confidentiality and how they could access the practice.

**Working age people (including those recently retired and students)**

Good

The practice is rated as good for the population group of working-age patients (including those recently retired and students.)

Nationally reported QOF data for 2013/14 showed patient outcomes relating to the conditions commonly associated with this population group were above the local CCG and England averages. For example, the data showed the practice had achieved 100% of the total points available to them for providing care and treatment for patients with cardiovascular disease. This was 6.7 percentage points above the local CCG average and 12 points above the England average. The needs of this group of patients had been identified and steps had been taken to provide accessible and flexible care and treatment. The practice was proactive in offering on-line services to patients. For example, patients could order repeat prescriptions and book appointments on-line. Extended hours appointments were available

# Summary of findings

from 7:30am four mornings a week and until 7:30pm one day a week. Health promotion information was available in the waiting area and on the practice web site. The practice provided additional services such as travel vaccinations and minor surgery.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable.

Nationally reported QOF data for 2013/14 showed the practice had achieved good outcomes in relation to patients with learning disabilities. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with learning disabilities. This was 10.1 percentage points above the local CCG average and 15.9 points above the England average. Staff worked with relevant community healthcare professionals to help meet the needs of vulnerable patients. The practice sign-posted vulnerable patients to various support groups and other relevant organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children and took action to protect vulnerable patients. Staff were aware of their responsibilities regarding information sharing, recording safeguarding concerns and contacting relevant agencies.

**People experiencing poor mental health (including people with dementia)**

The practice is rated as good for the population group of patients experiencing poor mental health (including people with dementia).

Nationally reported QOF data for 2013/14 showed the practice had achieved good outcomes in relation to patients experiencing poor mental health. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with mental health needs. This was 3.6 percentage points above the local CCG average and 9.6 points above the England average. The practice kept a register of patients with mental health needs which was used to ensure they received relevant checks and tests. Where appropriate, care plans had been completed for patients who were on the register. The practice regularly worked with other community healthcare professionals to help ensure patients' needs were identified, assessed and monitored. Patients were able to access on-site counselling and support provided by relevant professionals.

# Summary of findings

## What people who use the service say

During the inspection we spoke with five patients and reviewed four Care Quality Commission (CQC) comment cards completed by patients. The feedback we received indicated the majority of these patients were satisfied with the care and treatment they received. Most patients told us they received a good service which met their needs. Some of the patients we spoke to on the day of our inspection said they experienced difficulties getting through to the practice on the telephone and obtaining an appointment. However, the findings from the National GP Patient Survey of the practice, published in January 2015, sometimes differed from what some of the patients told us. Of the patients who responded to the survey: 87% said they found it 'easy' to get through to the practice on the telephone, (This was above both the local CCG average of 79% and the national average of 71%); but, only 82% said they had been able to get an appointment to see or speak to someone. (This was below the local CCG average of 85% and the national average of 86%.)

Other findings from the National GP Patient Survey for the practice, published in January 2015, indicated most patients had a good level of satisfaction with the care and treatment provided. For example, of the patients who responded to the survey:

- 89% said the last GP they saw, or spoke to, was good at listening to them. (This was just below the local CCG average of 92% but above the national average of 88%);
- 93% said the last GP they saw or spoke to was good at giving them enough time. (This was above both the local CCG average of 89% and the national average of 86%);
- 90% said the last GP they saw or spoke to was good at treating them with care and concern. (This was above both the local CCG average of 87% and the national average of 82%);
- 86% said the last GP they saw or spoke to was good at explaining tests and treatments. (This was in line with the local CCG average but above the national average of 82%);
- 98% said they had confidence and trust in the last GP they saw or spoke to. (This was above both the local CCG average of 96% and the national average of 93%).

These results were based on 112 surveys that were returned, out of a total of 334 sent out. The response rate was 34%.

## Areas for improvement

## Outstanding practice

- The practice is recognised by the Royal College of General Practitioners as a youth friendly practice. To achieve this, the practice had to demonstrate that they had developed services for younger patients by, for example, improving access and encouraging young patients to be actively involved in their care. The practice safeguarding lead had visited a local school and spoke with young people about confidentiality and how they could access the practice.

# Walker Medical Group

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team also included a practice manager and a GP

## Background to Walker Medical Group

Walker Medical Group provides care and treatment to 11352 patients of all ages, based on a Personal Medical Services (GMS) contract agreement for general practice. The practice is part of NHS Newcastle North and East Clinical Commissioning Group (CCG) and provides care and treatment to patients living in the North and East areas of Newcastle upon Tyne. The area in which the practice was situated had a greater degree of deprivation than any other area in Newcastle. The practice serves an area that has higher levels of deprivation for children and people in the over 65 age group, than the local CCG and England averages. The practice's population includes more patients aged under 18 years than the local CCG average, but less than the England average. The practice's population includes more patients aged over 65 years of age than other practices in the CCG area, but less than the England average.

The practice provides services from one location: The Walker Medical Group, Walker Centre, Church Walk, Walker, Newcastle upon Tyne. NE6 3BS. We visited this address as part of the inspection.

The practice occupies a purpose built building which houses other healthcare professionals such as community nursing staff and health visitors. The premises are fully accessible to patients with mobility needs. Walker Medical Group provides a range of services and clinic appointments including, for example, services and clinics for patients with asthma, diabetes and hypertension. The practice consists of five GP partners (four male and one female), a practice manager, an assistant practice manager, two nurse practitioners, two practice nurses, two healthcare assistants, and administrative and reception staff. The practice also employed two salaried GPs to provide extra sessions, and a sixth partner has recently been recruited.

When the practice is closed patients can access out-of-hours care via Northern Doctors Urgent Care and the NHS 111 service.

## 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.

## How we carried out this inspection

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

# Detailed findings

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

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

Before visiting we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the services it provided. We carried out an announced inspection on 12 February 2015. During this we spoke with a range of staff including: four GP partners; the practice manager; two practice nurses and members of the reception and administrative team. We spoke with five patients who visited the practice on the day of our inspection. We observed how staff communicated with patients who visited, or telephoned the practice, on the day of our inspection. We looked at records the practice maintained in relation to the provision of services. We also reviewed four Care Quality Commission (CQC) comment cards that had been completed by patients using the practice.

# Are services safe?

## Our findings

### Safe Track Record

When we first registered this practice, in April 2013, we did not identify any safety concerns that related to how it operated. Also, the information we reviewed as part of our preparation for this inspection did not identify any concerning indicators relating to safety. The Care Quality Commission (CQC) had not received any safeguarding or whistle-blowing concerns regarding patients who used the practice. The local Clinical Commissioning Group (CCG) did not raise any concerns with us about this practice.

The practice used a range of information to identify potential risks and to improve patient safety. This information included, for example, significant event reports, national patient safety alerts, and comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. The patients we spoke with, or who had completed comment cards, raised no concerns about safety at the practice.

We saw that records were kept of significant events and incidents. We reviewed a sample of the records completed by staff during the previous 12 months, as well as the minutes of meetings where these were discussed. These records showed the practice had managed such events consistently and appropriately during the period concerned and this provided evidence of a safe track record for the practice.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There was also evidence appropriate learning from incidents had taken place and that the findings were disseminated to relevant staff.

Eleven significant events had taken place since July 2014. The sample of significant event records we looked at included details about what the practice had learned from these events, as well as information about the changes that had been introduced to prevent reoccurrences. For example, the practice manager told us about an event where there had been a failure to communicate the outcome of a blood test to a patient. We were able to confirm that, following this incident, a standardised letter and procedure had been devised to ensure that this would not happen again. The practice manager also told us about an event where there had been a failure to forward a two-week wait referral to the correct hospital department. We saw evidence confirming that an internal email had been forwarded to all clinical practitioners reminding them of the need to use agreed templates when making such referrals. We saw that both of these incidents had been discussed during a significant event meeting, and the proposed changes had been implemented.

All of the staff we spoke with were aware of the system in place for raising issues and concerns. The practice also reported relevant incidents to the local CCG, using the local safeguarding incident reporting system. Arrangements had been made which ensured national patient safety alerts were disseminated by the practice manager to the relevant GP. This enabled these staff to decide what action should be taken to ensure continuing patient safety, and mitigate risks. For example, on receipt of safety advice about the use of a specific medicine to reduce feelings of sickness or being sick, the practice reviewed patients taking this medicine long-term and removed it from their prescription where this was judged appropriate. A log was maintained which provided evidence of all the actions taken in response to patient safety alerts.

### Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. Safeguarding policies and procedures were in place. Information about how to report safeguarding concerns and contact the relevant agencies was easily accessible for staff. One of the GP partners acted as the designated lead role for safeguarding children and adults. Staff we spoke with said they knew which GP acted as the safeguarding lead.

All the GPs and both of the nurse practitioners had completed child protection training to Level 3. This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns. The other clinical staff had completed Level 2 which was more relevant to the work they carried out. The administrative staff we spoke with

confirmed they too had completed child and adult safeguarding awareness training. A nurse practitioner we spoke with demonstrated a good understanding of how to protect and safeguard patients.

A chaperone policy was in place and information about this was displayed in the reception area and in the consultation rooms. The patients we spoke with said they knew they could access a chaperone if they needed one. All clinical and non-clinical staff who carried out chaperone duties had undertaken chaperone training.

Arrangements were in place to follow up children who failed to attend appointments, for example, to help ensure they did not miss important immunisations. Letters were sent to families where children had missed hospital appointments. The GPs met every three to four months with health visitors to review patients considered to be at risk and, where appropriate, to share any relevant information. Processes were in place for taking decisions about how the practice should respond to missed appointments, and for highlighting children at risk and 'looked after' children on their medical records. Following a significant event where staff had not reported a potential concern involving a child to the practice's child protection lead, staff had been reminded of the importance of correctly coding the siblings of children at risk as vulnerable children.

### Medicines Management

Arrangements were in place to check the storage of medicines requiring cold storage. Practice staff maintained a 'cold-chain' log which provided evidence that refrigerator temperatures were regularly checked to help ensure these medicines were stored correctly. We found all vaccines stored within the practice's three refrigerators were within their expiry date and had been stored in date order. We confirmed the practice did not hold any controlled drugs. (Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation, and stricter legal controls are applied to prevent them from being misused, obtained illegally or causing harm.)

The practice had effective arrangements for monitoring the expiry dates of emergency medicines and for ordering new supplies. We found all emergency medicines were in date. The practice manager told us all emergency calls into the practice were triaged by the on-call GP. We were told patients presenting with clinical symptoms such as Anaphylaxis were treated as emergencies and the 999 emergency ambulance service would be contacted, so that the patient could receive urgent medical treatment. For all other types of emergency calls, we were told the on-call GP would triage the needs of the patient and make a judgement about whether they needed to take an emergency medicines kit with them on the home visit. There were two emergency medicines kits available for use by the GPs. The kits contained a range of emergency medicines including adrenaline and rectal diazepam. Where the on-call GP had judged a home visit was needed, but that it was not in response to an emergency, they would take their doctor's bag which included the following emergency medicines: Aspirin; a GTN spray (treatment for angina); Benzyl Penicillin (medicine used to treat certain types of infections) and an inhaler. The GP partners had agreed these arrangements following a practice review, in January 2014, and the feedback they received during our inspection. When assessing what should be included in a doctor's bag for routine visits the GP partners had taken account of the advice on CQC's website and considered factors such as the proximity of the local hospital and the availability of 24 hour pharmacies. We were told that the palliative care pre-planning undertaken by staff at the practice helped to ensure that their patients had access to emergency medicines in their own homes.

Patients were able to order repeat prescriptions in a variety of ways, including visiting the practice, ordering by telephone, on-line and by post. The practice website provided patients with helpful advice about ordering repeat prescriptions. Reception staff handled telephone requests for repeat prescriptions competently and safely. They were clear about the processes they should follow, including checking that the number of authorised repeat prescriptions had not been exceeded. Repeat prescription requests were signed by GPs during the daily clinician meetings. The practice had implemented the Electronic Prescription System (EPS) the day before our inspection. This enables prescribers, such as GPs and nurses, to send prescriptions electronically to a pharmacy where this is the patient's preferred choice.

Following an incident involving the security of prescription pads, an effective system had been put in place to secure stocks of blank prescriptions during the day and when the practice was closed. For example, the practice manager said all blank prescriptions were removed from all printers at the end of each day.

# Are services safe?

## Cleanliness & Infection Control

The premises were clean and hygienic throughout. The patients we spoke with told us the premises were always clean. There was a cleaning schedule and a policies manual in the cleaning cupboard. This was well stocked and equipment was stored appropriately.

The clinical rooms we visited contained personal protective equipment such as latex gloves, and there were paper covers and privacy screens for the consultation couches. Arrangements had been made for the privacy screens to be laundered or replaced on a regular basis.

Spillage kits were available to enable staff to deal safely with spills of bodily fluids. Sharps bins were available in each treatment room to enable clinicians to safely dispose of needles. The bins had been appropriately labelled, dated and initialled. These rooms also contained hand washing sinks, antiseptic gel and hand towel dispensers to enable clinicians to follow good hand hygiene practice.

Arrangements had been made to ensure the safe handling of specimens and clinical waste. For example, reception staff were clear about how to handle specimens so that the spread of infection was reduced. All of the waste bins we saw were visibly clean and in good working order. We were also able to confirm that an up-to-date legionella risk assessment had been completed. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal).

An infection control policy and procedures were in place. These provided staff with guidance about the standards of hygiene they were expected to follow. The practice had an infection control lead who provided guidance and advice to staff when needed. The staff we spoke with confirmed they had completed infection control training.

A comprehensive infection control risk assessment and audit had been completed in November 2014, to help identify any shortfalls or areas of poor practice. A meeting involving key members of staff had been held following the audit to discuss the concerns identified and to agree what action was necessary. We saw evidence confirming that a follow up audit had been completed to check that the concerns identified had been actioned.

## Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. Minor surgery was carried out at the practice. We saw there were appropriate arrangements for the disposal of single-use surgical instruments.

Equipment was inspected and regularly serviced. Staff kept a maintenance log which provided evidence that there was a schedule for the regular maintenance of all equipment, including the practice's defibrillator and weighing scales. We saw that tests of all electrical equipment were due in March 2015. We were able to confirm that arrangements had been made to ensure that this happened. Fire equipment checks were also carried out regularly. The records we looked at confirmed other fire safety checks were carried out by the local NHS Estates Department. We saw that staff had received fire training within the last 12 months and that a full evacuation of the premises had taken place recently. A plan had been prepared following this, and we confirmed that action was being taken to implement this. The plan included, for example, sourcing fire warden training for two staff.

## Staffing & Recruitment

The practice had a recruitment policy which had been recently reviewed. This provided clear guidance about the pre-employment checks that should be carried out for new staff.

A range of checks had been undertaken to help make sure only suitable staff were employed. We looked at the records of a recently appointed member of staff. We saw they had undergone a Disclosure and Barring Service (DBS) check and references had been obtained. This person had submitted a curriculum vitae and application form which provided details of their previous employment. Evidence was available confirming they had received an induction. All GPs, nurses and non-clinical staff had a NHS Smart card (containing an identity photograph) which meant their identity had been verified under the NHS Employment Check Standards process.

The GP partners had each undergone a DBS check as part of their application to be included on the National Medical Performers' List. (All performers are required to register for the online DBS update service which enables NHS England

# Are services safe?

to can carry out status checks on their certificate.) We checked the General Medical and Nursing and Midwifery Councils registers and confirmed all of the clinical staff working at the practice were licensed.

### Monitoring Safety & Responding to Risk

Systems had been put in place to manage and monitor risks to patients and staff. For example, staff had carried out regular 'housekeeping' audits to check that the premises were safe and hazard free. An up-to-date fire risk assessment was in place and provided evidence that the practice had assessed the risks posed to staff and patients. We checked the building and found it to be safe and hazard free. None of the patients we spoke to raise any concerns about health and safety.

Staff at the practice had completed significant event reports where concerns about patients' safety and well-being had been identified. Arrangements were in place to learn from patient safety incidents and promote learning within the team.

### Arrangements to deal with emergencies and major incidents

Arrangements had been put in place to manage emergencies. For example, we looked at a sample of records which showed staff had received training in cardio-pulmonary resuscitation (CPR). There was equipment available for use in emergencies including an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and emergency medicines kits for use by the duty doctor carrying out home visits. The staff we spoke with knew the location of this equipment and checks were undertaken to make sure they were in good working order and fit for purpose.

An up-to-date business continuity plan for dealing with a range of potential emergencies that could impact on the daily operation of the practice was in place. The plan covered the actions to be taken to reduce and manage a range of potential risks. All GP partners and the practice manager had their own copy of the plan loaded onto an encrypted memory stick which they could access out-of-hours. We found the practice was active in assessing risks and regularly updated their business continuity plan.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. All clinical staff had access to local guidelines, as well as guidelines from the National Institute for Health and Care Excellence (NICE) via the practice intranet. A GP we spoke with told us they had lead responsibilities for chronic disease management and reviewing and updating practice guidelines and clinical protocols. They also told us significant changes to either existing NICE or local guidelines would be reviewed at clinical meetings, or as part of a significant event meeting.

From our discussions with clinical staff we were able to confirm they completed thorough assessments of patients' needs which were in line with NICE guidelines. Patients' needs were reviewed as and when appropriate. Nursing staff told us they had access to a range of chronic disease management templates. They said these were used to record details of the assessments they had carried out and any agreements reached with patients about how they should manage their condition.

Practice staff had the knowledge, skills and competence to enable them to respond appropriately to patients' needs. The practice manager showed us a comprehensive training plan which included details of the training staff had completed. This confirmed staff had completed a range of training including, for example, in safeguarding patients and carrying out Cardio-Pulmonary Resuscitation (CPR.)

Interviews with clinical staff demonstrated the culture in the practice was that patients were referred to relevant services on the basis of need. Patients' age, sex and race was not taken into account in this decision-making. There were in plans in place for staff to complete equality and diversity training.

### Management, monitoring and improving outcomes for people

Staff across the practice had key roles in managing, monitoring and improving outcomes for patients. For example, GPs held clinical lead roles in a range of areas, including cancer and sexual health. Other clinical and non-clinical staff had been given responsibilities for carrying out a range of designated roles including, for example, making sure emergency drugs were up-to-date and fit for use.

The practice used the information collected for the Quality and Outcomes Framework (QOF), and information about its performance against national screening programmes, to support the practice to carry out clinical audits, and to monitor and improve outcomes for patients. Nationally reported QOF data for 2013/14 showed the practice had achieved 99.8% of the total points available to them for providing recommended treatments to patients with the commonly found health conditions covered by the scheme. This was 4.9 percentage points above the local Clinical Commissioning Group (CCG) average and 6.3 points above the England average. The practice had met all but one of the minimum standards for QOF including, for example, those covering asthma/ chronic obstructive pulmonary disease (lung disease)/ epilepsy and heart failure. Although the practice had only obtained 98.2% of the overall points available to them for providing recommended care to diabetic patients, their performance in this area was still 4.7 percentage points above the local CCG average and 8.1 points above the England average. The practice was not an outlier for any QOF (or other national) clinical targets.

A range of clinical audits had been carried out to help improve patient outcomes. This included an audit of patients with heart failure to help ensure they had been prescribed the most effective medicines at the right dosage. We saw that where the audit findings indicated patients were not receiving the maximum therapeutic doses for their condition, the practice had carried out a review and made changes to their medicines where this was considered necessary. The audit had also included a search for patients with specific types of long-term conditions where undiagnosed heart failure could be present. We saw that as results of this, the small number of patients with undiagnosed heart failure were able to access appropriate treatment.

We looked at one clinical audit which had been carried out by one of the GP partners to check whether women fitted with a contraceptive device (a coil) were attending for a follow-up check three to six weeks after fitting, in line with current guidance. We were told the practice had encouraged women to make a follow up appointment with a nurse immediately after being fitted with the device. We

# Are services effective?

## (for example, treatment is effective)

saw evidence confirming the GP had then re-audited the original findings to see if the action taken by the practice had improved attendance rates for follow-up appointments. The figures showed there had been a 27% increase in the number of woman attending for a check-up within three to six weeks of the procedure being carried out.

In conjunction with an external nurse clinician, an audit had been carried out to identify patients at high risk of stroke due to Atrial Fibrillation (irregular heart rhythm) who had not been prescribed an anticoagulant. To support this, a local community cardiologist had provided clinicians with training. We were told affected patients had been contacted so that an appropriate medicine could be prescribed. A re-audit had been scheduled to take place shortly after the date of our inspection.

A number of other clinical audits had also been carried out. For example, the practice manager told us a yearly cervical (smear) test audit was carried out to check the rate of inadequate smear test results was acceptable. A monthly audit was also carried out to check for any out-of-date Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) forms. Where these forms had either expired or were approaching their expiry dates, these were reviewed by a GP and resigned where appropriate.

Effective systems were in place which helped to ensure patients received prompt and safe care and treatment. For example, all discharge and other advisory letters, and electronic test results, were reviewed by one of the GPs to ensure appropriate action was taken. Where patients had been prescribed medicines that required careful and regular monitoring, searches of medical/prescribing records were carried out to identify which patients required this intervention.

### Effective staffing

The staff team included medical, nursing, managerial and administrative staff. The partnership consisted of five GP partners. The GPs had completed additional training to help them deliver appropriate care and treatment to patients. For example, the practice safeguarding lead had completed the Diploma of Community Child Health, and undertook twice yearly updates. Another GP had completed a Diploma in Family Planning and had undertaken additional training to enable them to fit contraceptive devices. They had also completed a recognised course in minor surgery.

All the GPs were up-to-date with their annual continuing professional development requirements and had dates for their revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England.)The majority of staff had received an appraisal during the previous 12 months. Arrangements had been made to provide the remaining staff with their yearly appraisal.

Nurses working at the practice told us they were only expected to provide chronic disease management for which they had received appropriate training. One nurse told us they had completed recognised training in diabetes and carrying out cervical (smear) tests. They confirmed the practice was proactive in providing them with access to appropriate training that was relevant to their role.

Appropriate arrangements had been made to ensure the practice was appropriately staffed. The practice had a holiday protocol which was rigorously adhered to. This helped to ensure that sufficient numbers of clinical and non-clinical staff were always rostered on duty. Succession planning was underway at the time of our inspection. Succession planning helps teams to plan in advance for any foreseeable changes in their staff group. The practice manager told us a capacity and demand exercise (comparing available capacity (numbers of staff and appointments) with the demand from patients) was due to be undertaken to ensure the practice had the right number of staff with the required skills and competencies to meet patients' needs.

### Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. The practice received written communications from local hospitals, the out-of-hours provider and the 111 service, both electronically and by post. Staff we spoke to were clear

# Are services effective?

## (for example, treatment is effective)

about their responsibilities for reading and actioning any issues arising from communications with other care providers. They understood their roles and how the practice's systems worked.

The practice held regular multi-disciplinary meetings to discuss patients with complex needs, for example, those with end-of-life care needs. These meetings were attended by the GPs, practice nursing staff as well as local healthcare professionals, such as health visitors and midwifes.

The practice had established links with the nine care home within its catchment area. Each care home had a named GP at the practice to help promote better care and support for their residents. Meetings with care home managers had been held to look at developing more effective joint working processes.

### Information Sharing

The practice had systems in place to provide staff with the information they needed to carry out their roles and responsibilities. An electronic patient record was used by all staff to coordinate, document and manage patients' care. The administrative staff we spoke with told us they had been trained in how to use the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used several systems to communicate with other providers. For example, there was an agreed process for accessing information from the local out-of-hours provider which ensured the practice received written information about any contact with its patients. The practice shared information about patients with complex care and treatment needs, or those who had an agreed Do Not Attempt CPR order in place, with the out-of-hours and urgent care providers. These arrangements helped ensure important information about patients' needs was shared in a secure and timely manner. Electronic systems were also in place for making referrals using 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).

### Consent to care and treatment

Staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in complying with it. The GP partners and nursing staff we spoke with demonstrated a clear understanding of consent and capacity issues. They were able to clearly explain when consent was necessary and how it would be obtained and recorded.

The practice had a consent policy which provided clinical staff with guidance about how to obtain patients' consent to care and treatment, and what to do in the event a patient lacked the capacity to make an informed decision. This policy also highlighted how patients' consent should be recorded in their medical notes, and it detailed what type of consent was required for specific interventions.

### Health Promotion & Prevention

The practice offered all new patients a health check with a healthcare assistant. These checks covered a range of areas including height, weight and blood pressure. The practice had previously offered NHS Health Checks to all patients aged between 40 and 75 years of age to help prevent heart disease, stroke, diabetes and kidney disease. However, the partners had recently stopped offering this optional enhanced service in order to reduce workload pressures on their nursing team and to better support the nursing staff in providing care and treatment to patients with chronic diseases.

The practice was good at identifying patients who needed additional support and were proactive in offering this. For example, there was a register of all patients with dementia. The QOF data for 2013/14 showed that the practice had obtained 100% of the points available to them for providing recommended clinical care and treatment to dementia patients. The data indicated, for example, that 90% of patients with dementia had received a range of specified tests, six months before or after being placed on the practice's register. This was 5.6 percentage points above the local CCG average and 9.8 points above the England average.

The QOF data for 2013/14 confirmed the practice supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy. The data showed the practice had obtained 100% of the points available to them for providing support with smoking cessation. This was 6.4 percentage points above the local CCG average and 6.3 points above the England average. The practice had also obtained 100%

# Are services effective?

## (for example, treatment is effective)

of the points available to them for providing cervical screening to women. This was 3.2 percentage points above the local CCG average and 2.5 points above the England average.

# Are services caring?

## Our findings

### Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice regarding levels of patient satisfaction. This included information from the National GP Patient Survey for the practice, published in January 2015. The evidence from these sources showed the majority of patients were satisfied with how they were treated and the quality of the care and treatment they received. For example, of the patients who responded to the National Patient Survey: 93% said the last GP they saw, or spoke to, was good at giving them enough time. (This was above both the local CCG average of 89% and the national average of 86%); 89% said the last GP they saw, or spoke to, was good at listening to them. (This was just below the local CCG average of 92% but above the national average of 88%); 98% said the last GP they saw, or spoke to, was good at treating them with care and concern. (This was above both the local CCG average of 87% and the national average of 82%). We received four completed Care Quality Commission (CQC) comment cards. The feedback received from these patients was mostly positive. We also spoke with five patients on the day of our inspection. Patients confirmed practice staff treated them with dignity, respect and compassion.

During the inspection all consultations and treatments were carried out in the privacy of a consulting or treatment room. There were screens in these rooms to enable patients' privacy and dignity to be maintained during examinations and treatments. Consultation and treatment room doors were kept closed when the rooms were in use, so conversations could not be overheard. Patients were able to access a private room if they wished to talk confidentially to reception staff.

### Care planning and involvement in decisions about care and treatment

Data from the National GP Patient Survey for the practice, published in January 2015, showed patients were positive about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, 80% of respondents said their GP involved them in decisions about their care. (This was just below the local CCG average of 83% but above the national average of 74%); 86% felt the GP was good at explaining treatment and results. (This was in line with the local CCG average but above the national average of 82%). Three of the patients who completed CQC comment cards did not raise any concerns in this area and neither did any of the patients we spoke to on the day of our inspection.

Practice staff told us translation and interpreter services were available for patients who did not speak English as a first language. Providing these services helps to promote patients' involvement in decisions about their care and treatment. Reception staff were aware of the need to book double appointments for patients unable to speak English.

### Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by practice staff. The responses from patients who completed CQC comment cards, and from the patients we spoke with during the inspection, indicated they were satisfied with the care and support they received. None of the patients we spoke with raised any concerns about the support they received to cope emotionally with their care and treatment.

We observed staff in the reception area treating patients with kindness and compassion. Notices and leaflets in the waiting room sign-posted patients to organisations offering patients support with coping with loss. Clinical staff also referred patients struggling with loss and bereavement to these services.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

For example, the practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of older patients and those with long-term conditions. They had used a risk assessment tool to profile patients according to the risks associated with their conditions. This had enabled practice staff to identify patients at risk of, for example, an unplanned admission into hospital. The practice kept a register of these patients, and had written to each patient aged 75 years and over, explaining which GP would act as their named doctor.

The practice nursing team was responsible for delivering most of the chronic disease care and treatment needed by patients. The practice offered patients with long-term conditions, such as asthma and Chronic Obstructive Pulmonary Disease (COPD), an annual check of their health and wellbeing, or more often where this was judged necessary by the nursing team. Of the patients who participated in the National GP Patient Survey for the practice, published in January 2015: 81% said the last nurse they saw was good at explaining tests and treatment. (This was above both the local Clinical Commissioning Group (CCG) average of 79% and the national average of 78%); 85% said they had confidence and trust in the last nurse they saw or spoke to. This was in line with the local CCG average of 85% but slightly below the national average 86%); 68% of patients said they received enough help to manage their long-term condition/s. (This was above the local CCG average of 64% and the national average of 64%).

The practice had made good arrangements for meeting the needs of patients requiring palliative care. The Quality and Outcomes Framework (QOF) data for 2013/14 showed the practice had obtained 100% of the points available to them for providing recommended care and treatment to patients needing palliative care. (This was 5.9 percentage points above the local CCG average and 3.3 points above the England average). The practice kept a register of patients who were in need of palliative care and their IT system alerted clinical staff about those who were receiving this care. QOF data showed that multi-disciplinary team (MDT) meetings took place at least every three months, to discuss and review the needs of each patient on this register. Staff told us these meetings included relevant healthcare professionals involved in supporting patients with palliative care needs, such as community nurses and health visitors.

We were shown documentary evidence which confirmed the practice had performed well in supporting patients with end of life needs to have a supported death at home. This showed the practice had, for example, planned and supported more patients to die in their own home than the national average. As part of their commitment to providing good palliative care, one of the GP partners acted as a Macmillan GP for cancer and end of life care. Staff had developed a bereavement letter which was sent out to relatives who had suffered the loss of a family member. In 2015, the practice was involved in piloting new care planning documentation for use with patients with end of life needs.

The practice had identified the needs of families, children and young people, and put plans in place to meet them. Pregnant women were able to access an antenatal clinic provided by healthcare staff attached to the practice. The practice had obtained 100% of the QOF points available to them for providing recommended maternity services and carrying out specified child health surveillance interventions. (These achievements were above the England averages (i.e. 0.9 and 1.2 percentage points above respectively) and in line with the local CCG averages. The QOF data showed antenatal care and screening were offered in line with current local guidelines. The data also showed that child development checks were offered at intervals consistent with national guidelines.

The practice held a twice weekly mother and baby clinic. This provided mothers with access to various healthcare checks and any support they needed from the health visitor who attended the clinic. One of the GPs also carried out eight week baby health checks. Practice staff had worked with local health visitors to promote breastfeeding and posters promoting this were displayed in the practice. The practice offered a full range of immunisations for children. Where comparisons allowed, we found the delivery of childhood immunisations was higher when compared with

# Are services responsive to people's needs?

## (for example, to feedback?)

the overall percentages of children receiving the same immunisations within the local CCG area. For example, seven of the eight childhood immunisations given to children aged five years were above the local CCG averages.

The practice is recognised by the Royal College of General Practitioners as a youth friendly practice. To achieve this, the practice had to demonstrate that they had developed services for younger patients by, for example, improving access and encouraging young patients to be actively involved in their care. The practice safeguarding lead had visited a local school and spoke with young people about confidentiality and how they could access the practice. The practice had offered a drop-in clinic for younger patients, but the take-up rate had been poor and was no longer provided. The practice operated the C-Card scheme which enabled young people to access condoms and advice about sexual health.

The practice had planned its services to meet the needs of the working age population, including those patients who had recently retired. They provided an extended hours service from 7:30am four days a week and until 7:30pm one evening a week, to facilitate better access to appointments for working patients. The practice website provided patients with information about how to book appointments and order repeat prescriptions.

### Tackle inequity and promote equality

Some patients registered with the practice were at risk of experiencing poor access to health care. The area in which the practice was situated had a greater degree of deprivation than any other area in Newcastle. The staff we spoke with demonstrated an understanding of the impact that deprivation had on patients' health and wellbeing, and spoke clearly of the steps they were taking to meet the needs of patients affected by this. For example, the practice acted as a reception centre for asylum seekers and provided healthcare and advice to this group of people.

The practice had made suitable arrangements to identify and meet the needs of patients with learning disabilities and those with complex health conditions. QOF data indicated that they had provided recommended care and treatment to this group of patients. The practice had obtained 100% of the total points available to them for providing these services. (This was 10.1 percentage points above the local CCG average and 15.9 points above the national average.)

Reasonable adjustments had been made which helped patients with disabilities and patients whose first language was not English, to access the practice. The premises had been designed to meet the needs of patients with disabilities. For example, the clinical and consultation rooms, and the reception area, were located on the ground floor. There was a disabled toilet which had appropriate aids and adaptations. Doors providing access to the practice had been automated to improve access. Disabled parking was available at the front of the building. The waiting area was spacious making it easier for patients in wheelchairs to manoeuvre. The practice had a number of patients whose first language was not English. Practice staff had access to a telephone translation service and interpreters should these be required. The patient self check-in screen was available in 15 different languages to assist the booking-in process.

### Access to the service

Appointments were available from 7:30am to 6:30pm four days a week and between 8am and 7:30pm one day a week. Providing extended hours makes it easier for working age patients and families to obtain a convenient appointment. Patients were able to book appointments by telephone, by visiting the practice or on-line via the practice web site. The practice offered a variety of different appointment types, such as urgent and routine. Routine appointments could be booked up to 30 days in advance.

The practice employed two nurse practitioners who had their own surgeries which patients were able to book directly. The GPs we spoke with told us patients who requested a named doctor sometimes had to wait a short while before being seen. However, they said that anyone who needed to be seen quickly would always be accommodated. The GPs told us children, babies and older patients were always given priority and we saw evidence of this during the inspection.

Overall, feedback from the National GP Patient Survey for the practice indicated they performed well in meeting patients' expectations regarding access to appointments. Of the patients who participated in the survey: 93% said they were satisfied with the practice's opening hours. (This was above the local CCG average of 82% and national average of 76%); 82% said they were able to get an appointment to see or speak with someone. (This was just below the local CCG of 85% and the national average of 86%); 87% said they found it 'easy' to get through on the

# Are services responsive to people's needs?

## (for example, to feedback?)

telephone to someone at the practice. (This was above both the local CCG average of 79% and the national average of 71%); 74% said they usually waited 15 minutes or less after their appointment time to be seen. (This was above both the local CCG average of 70% and the national average of 65%).

However, three of the four patients we spoke with said they sometimes found it difficult to get through to the practice on the telephone and obtain an appointment. We shared this feedback with the practice team who said they were already aware of this and were taking action to address patients' concerns. For example, the practice manager told us the practice had six telephone lines and to reduce usage of these during peak times, the practice manager and the GPs used their mobile phones to make outgoing professional calls. Also, an analysis of the appointments system had recently been carried out with a view to obtaining a better understanding of the demand for appointments, what worked well, and what improvements could be made. There were plans to carry out an audit of the occasions when patients failed to attend appointments to look at what measures could be taken to reduce them. The inspection team felt the practice was being proactive in addressing patients' concerns about access to appointments.

The practice's website provided patients with information about how to access out-of-hours care and treatment, including appropriate emergency care. When the practice was closed there was an answerphone message giving the relevant telephone numbers patients should ring.

### Listening and learning from concerns and complaints

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

Information was available to help patients understand the complaints process. The practice website provided patients with clear information about how to complain, and included timescales within which concerns would be addressed. The practice's complaints procedure, which could be downloaded from their website, stated that patients would receive an apology where the practice had not got things right. Information about how to complain was also available within the reception area of the practice.

The practice had maintained a record of all of the complaints they had received. There had been eight complaints during the previous 12 months. The majority of these had been resolved. The practice had referred one of these complaints to NHS England, so that the complainant could receive an independent view of how the practice had responded to the concerns they had raised. From the information supplied by the practice we were able to confirm they responded appropriately to concerns raised by patients. The complaints record contained evidence that lessons were learned following each complaint. The practice manager told us an annual complaints meeting was held to discuss any complaints received. We saw documentary evidence confirming this.

# Are services well-led?

(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. Information about this was available on their website. This stated, "We are a forward thinking practice with a long history of commitment to the community. We aim to provide optimum care and to perform to the best of our ability." The practice had a clear set of aims and objectives, including: "To provide the optimum care that respects individuals' needs and wishes through a skilled and friendly team working together to give a comprehensive, confidential, accessible, high quality and caring service." The practice provided the inspection team with a clear statement about the services they provided to the key population groups we looked at. Staff told us they knew and understood what the practice was committed to providing and what their responsibilities were in relation to these aims. There was evidence the practice had carefully considered the future demands likely to be placed on the service, such as the forthcoming retirement of one of the partners.

### Governance Arrangements

Arrangements for assessing, monitoring and addressing risks were in place. For example, the practice had a business continuity plan to help ensure the service could be maintained in the event of foreseeable emergencies. The practice manager told us that, where concerns were identified which might have a negative impact on patients, these were discussed with the partners to enable appropriate responses to be made.

Regular meetings, involving staff at all levels, were held to enable effective decision-making and shared learning to take place. For example, there were daily GP meetings and a monthly partnership meeting was held to deal with business issues affecting the day-to-day operation of the practice. Some staff felt they were not fully involved with discussions that were relevant to the practice and their roles within the team. They told us there was lack of regular nursing team meetings and structured contact time with the GPs.

Arrangements were in place which supported the identification, promotion and sharing of good practice. For example, a system was in place which ensured significant events were discussed within the practice team. Staff were encouraged and supported to learn lessons where patient outcomes were not of the standard the practice expected. The practice had carried out a range of clinical audits to help improve patient outcomes.

The practice had made arrangements to monitor its clinical performance. Nationally reported Quality and Outcomes Framework (QOF) data for 2013/14 confirmed the practice participated in an external peer review with other practices in the same Clinical Commissioning Group (CCG), in order to compare data and agree areas for improvement. (Peer review enables practices to access feedback from colleagues about how well they are performing against agreed standards.) Regular checks of the practice disease registers were carried out to make sure patients received recommended levels of care and treatment.

The practice had a range of policies and procedures in place governing its activities and the services it provided to patients. Staff were able to access these via the shared computer drive.

### Leadership, openness and transparency

There was a well-established management structure and a clear allocation of responsibilities, such as clinical lead roles. All of the staff we spoke with demonstrated a good understanding of their areas of responsibility and were able to describe how they took an active role in trying to ensure patients received good care and treatment. Staff told us they would feel comfortable raising concerns with the practice management team or the GP partners.

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

The practice had made arrangements to actively seek and act on feedback from patients and staff. For example, patients were invited to complete a Friends and Family Test (FFT) following a visit to the practice. Feedback from the January 2015 FFT survey showed that 72.2% of patients would be likely to recommend the practice to their family and friends. Information about how to access the FFT was available in the practice's reception area.

The practice had an active patient participation group (PPG). Information about how to join the group was available in the reception area and on the practice website. The PPG met six times during 2014 to discuss issues they and the practice considered important. Minutes of these

# Are services well-led?

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

meetings were available on the practice website. These provided evidence of discussion regarding a range of key issues, such as improving access to appointments and promoting a breast feeding initiative. The final PPG meeting in 2014 had included a presentation on palliative care by one of the GPs, to help promote the members' understanding of this area.

The practice had gathered feedback from staff through regular staff meetings and the use of staff appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

### Management lead through learning & improvement

The practice provided staff with opportunities to continuously learn and develop. The staff we spoke with told us they had opportunities for learning to enable them to maintain and develop their skills and competencies. All of the staff we spoke to said their personal development was encouraged and supported. Staff said they took part in regular 'time-out' sessions which enabled them to complete the training required for their continuing professional development.

The practice demonstrated their strong commitment to learning by providing opportunities for GP Registrars to complete their specialist training. They had achieved accreditation as a training practice. This meant they had to meet higher than usual standards of performance in areas such as patient medical records and providing a safe working environment. The practice also provided opportunities for undergraduate medical students to work alongside the GPs. Two of the GPs acted as appraisers for other GPs in the Northern Region.

Reviews of significant events had also taken place and the outcomes had been shared with staff via meetings and the practice intranet. This helped to ensure the practice improved outcomes for patients through continuous learning.