# Biddlestone Health Group

## Quality Report

Biddlestone Road
Newcastle Upon Tyne
Tyne And Wear
NE6 5SL
Tel: 0191 2655755
Website: www.biddlestonehealthgroup.co.uk

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

## Ratings

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

# Summary of findings

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## Overall summary

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

We carried out an announced comprehensive inspection at Biddlestone Health Group on 12 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for the following population groups: 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).

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

- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Risks to patients were assessed and well managed.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about services and how to complain was available and easy to understand.
- There was a clear leadership structure and staff felt supported by management. The practice pro-actively sought feedback from staff and patients, which it acted upon.
- The practice had an active patient participation group (PPG), which included representation from a wide range of backgrounds. The practice worked in partnership with the group to improve services for their patients.

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

The provider should

- Endeavour to increase both the recording and learning from significant events. The number of recorded significant events was less than expected for the

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practice size, with three recorded since April 2014. We found they were correctly actioned and investigated, but concentrated exclusively on negative events rather than also celebrating good practice and recording compliments.

- Ensure that any complaints received are responded to in line with practice's policy. The practice's complaints policy stated 'We shall acknowledge your complaint within 2 working days'; however the records we looked at showed this had not always happened.
- Ensure that all clinical audits measure whether agreed standards have been achieved or make recommendations and take action where standards are not being met. There was evidence of audits having been undertaken which was relevant to individual clinical practice by some clinicians, however the majority of evidence presented was a review (i.e. the first part of an audit), and there was limited evidence of completed audit cycles.
- Continue to review access for patients who require urgent appointments. Nationally reported data and feedback we received from patients themselves suggested they found it difficult at times to get an appointment with a GP when they felt their need was urgent.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated across the staff team to support improvement. However, the number of recorded significant events was less than expected for the practice size, with three recorded since April 2014. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There was enough staff to keep people safe.

**Are services effective?**

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring its effectiveness and had achieved 99.3% of the points available. This was higher than the local and national averages. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for some staff, with appraisals planned for others. Staff worked with multidisciplinary teams which helped to provide effective care and treatment. Not all of the clinical audits completed measured whether agreed standards had been achieved or made recommendations and took action where standards were not being met.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice in line with others for several aspects of care. For example, the latest National GP Patient Survey results showed 84% of respondents said the last GP they saw or spoke to and 88% said the last nurse they saw or spoke to was good at involving them in decisions about their care. Both these results were better than the local Clinical Commissioning Group (CCG) area averages, which were 83% and 68% respectively. Patients said they were treated with compassion, dignity and respect and they were

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involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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

Good

The practice is rated as good for providing responsive services. They reviewed the needs of their local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Most patients said they found it easy to make an appointment with a GP; however some patients suggested they found it difficult at times to get an appointment with a GP when they felt their need was urgent. 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; however evidence showed the practice did not always respond to issues raised in line with the timescales stated within their own policy. Learning from complaints was shared with staff. The practice had an active patient participation group (PPG), which included representation from a wide range of backgrounds. The practice worked in partnership with the group to improve services for their patients.

**Are services well-led?**

Good

The practice is rated as good for being well-led. They had a number of aims and objectives and staff were clear about their responsibilities in relation to these. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which they acted upon. The patient participation group (PPG) was active. Staff had received inductions, performance reviews and attended staff meetings and events.

# Summary of findings

## The six population groups and what we found

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

**Older people**

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. For example, all patients over the age of 75 had a named GP and patients at high risk of hospital admission had a named GP and a care plan. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. The practice maintained a palliative care register.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. GPs and nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Patients at high risk of hospital admission had a named GP and structured reviews to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health care professionals to deliver a multidisciplinary package of care. The practice had recall arrangements in place to ensure patients with long term conditions were reviewed on a regular basis. They used the Quality and Outcomes Framework (QOF) as one method of monitoring their effectiveness and had achieved 99.3% of the points available. This was higher than the local and national averages.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were in line with local averages for all standard childhood immunisations. For example, Hib/Men C Booster vaccination rates for five year old children were 90.1% compared to 93.9% across the CCG; and MMR Dose 2 vaccination rates for five year old children were 94.5% compared to 92.7% across the CCG. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

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Cervical screening rates for women aged 25-64 were well above the national average at 91.4%, compared to 81.9% nationally. The practice manager said they sent a second invite letter out to their eligible patients if they didn't respond to the first letter sent out to them by the NHS Cervical Screening Programme. They felt this may contribute to their higher than average performance.

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

Good

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

The practice offered extended opening hours. Appointments were available until 8.00pm on Monday evenings and patients could choose to see a GP or practice nurse. This made it easier for people of working age to get access to the service.

**People whose circumstances may make them vulnerable**

Good

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

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

Patients with no fixed abode were welcomed into the practice and could register with them the same as any other patient.

**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). They regularly

# Summary of findings

worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. They carried out advance care planning for patients with dementia. They had participated in a number of recent initiatives around dementia. As a result, they had increased their register for patients diagnosed with dementia from 58 to 72 since October 2014.

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

# Summary of findings

## What people who use the service say

The 17 patients we spoke with were largely complimentary about the services they received at the practice. They told us the staff who worked there were helpful and friendly. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were generally happy with the appointments system, although some patients were not as satisfied with access to same-day appointments. We mentioned this to the practice manager and GPs, who said this feedback would be included as part of the ongoing review of the appointments system.

We reviewed 17 CQC comment cards completed by patients prior to the inspection. The large majority were complimentary about the practice, staff who worked there and the quality of service and care provided. Of the 17 CQC comment cards completed, 13 patients made direct reference to the caring manner of the practice staff. Words used to describe the approach of staff included helpful, kind, understanding, friendly, polite, caring and respectful.

The latest National GP Patient Survey showed patients were mostly satisfied with the services the practice offered. The results were mainly in line with other GP practices within the local Clinical Commissioning Group (CCG) area. The results were:

- The proportion of respondents who were able to get an appointment to see or speak to someone the last time they tried – 82% (CCG average 85%);
- The proportion of respondents who said the last GP they saw or spoke to was good at explaining tests and treatments – 87% (CCG average 87%);
- The proportion of respondents who said the last GP they saw or spoke to was good at involving them in decisions about their care – 84% (CCG average 83%);
- The proportion of respondents who said they had confidence and trust in the last GP they saw or spoke to – 96% (CCG average 98%);
- The proportion of respondents who said the last nurse they saw or spoke to was good at explaining tests and treatments – 91% (CCG average 77%);
- The proportion of respondents who said the last nurse they saw or spoke to was good at involving them in decisions about their care – 88% (CCG average 68%);
- The proportion of respondents who said they had confidence and trust in the last nurse they saw or spoke to – 98% (CCG average 97%).

These results were based on 107 surveys that were returned from a total of 318 sent out; a response rate of 34%.

The practice also sought feedback from patients by completing its own patient surveys; the most recent of which was completed in October 2014. The survey focused on the 'Friends and Family' style questionnaire that would be formally introduced in December 2014. Of the 155 surveys completed, 144 (92.9% of respondents) said they were likely or extremely likely to recommend the practice. Even though this feedback was largely positive, a number of actions had been agreed with the practice's patient participation group (PPG).

The practice had also started to analyse their actual friends and family test results, which was introduced into general practice in December 2014. Results from feedback received in January 2015 (from patients who attended the practice in December 2014) showed 21 of 23 (91.3%) patients who responded said they were likely or extremely likely to recommend the practice. The average score awarded to the practice by the 23 respondents was four and a half out of five stars.

## Areas for improvement

**Action the service SHOULD take to improve**

- Endeavour to increase both the recording and learning from significant events. The number of recorded significant events was less than expected for the

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practice size, with three recorded since April 2014. We found they were correctly actioned and investigated, but concentrated exclusively on negative events rather than also celebrating good practice and recording compliments.

- Ensure that any complaints received are responded to in line with practice's policy. The practice's complaints policy stated 'We shall acknowledge your complaint within 2 working days'; however the records we looked at showed this had not always happened.
- Ensure that all clinical audits measure whether agreed standards have been achieved or make recommendations and take action where standards are not being met. There was evidence of audits having been undertaken which was relevant to individual clinical practice by some clinicians, however the majority of evidence presented was a review (i.e. the first part of an audit), and there was limited evidence of completed audit cycles.
- Continue to review access for patients who require urgent appointments. Nationally reported data and feedback we received from patients themselves suggested they found it difficult at times to get an appointment with a GP when they felt their need was urgent.

# Biddlestone Health Group

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector. The team included a GP and an Expert By Experience. An expert by experience is somebody who has personal experience of using or caring for someone who uses a health, mental health and/or social care service.

## Background to Biddlestone Health Group

The practice is located close to Chillingham Road in Heaton, Newcastle upon Tyne. The practice serves those living in Heaton and the surrounding areas, from Longbenton in the North to Walker in the South. The practice provides services from the following address and this is where we carried out the inspection:

Biddlestone Road, Newcastle Upon Tyne, Tyne And Wear, NE6 5SL.

The practice provides its services to patients at ground and first floor levels, and some offices for staff are on the first floor. Patients who access services on the first floor are escorted to and from the treatment and consulting rooms by a member of staff. The practice offers on-site parking including disabled parking, accessible WC's and step-free access. The practice provides services to around 9,500 patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

The practice has five GP partners and one salaried GP. The practice is a training practice, with one attached GP Registrar (a fully qualified doctor, allocated to the practice as part of their three year specialist training) and one F2 foundation doctor (a fully qualified doctor allocated to the practice as part of a two-year, general postgraduate medical training programme). There are also three practice nurses, one healthcare assistant, a practice manager and a team of eight administrative support staff.

The CQC intelligent monitoring system placed the area in which the practice was located in the fourth less deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The practice's age distribution profile showed the practice had a larger percentage of patients between the ages of 20 and 34 years old than the England averages; both for male and female patients.

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

## Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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.

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

# Detailed findings

## How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

• Older people

• People with long-term conditions

• Families, children and young people

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

• People whose circumstances may make them vulnerable

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

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. This included the local Clinical Commissioning Group (CCG). This did not highlight any significant areas of risk across the five key question areas.

We carried out an announced visit on 12 February 2015. We visited the practice's surgery in Heaton, Newcastle upon Tyne. We spoke with 17 patients and a range of staff from the practice. We spoke with the practice manager, three GPs, an F2 foundation doctor (a fully qualified doctor allocated to the practice as part of a two-year, general postgraduate medical training programme), three practice nurses, a health care assistant and some of the practice's administrative and support staff. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 17 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

As part of our planning we looked at a range of information available about the practice. This included information from the latest GP Patient Survey results published in January 2015 and the Quality and Outcomes Framework (QOF) results for 2013/14. The latest information available to us indicated there were no areas of concern in relation to patient safety.

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed Care Quality Commission (CQC) comment cards reflected this.

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said they all had responsibility to report and record matters of safety. For example, an incident had been recorded where some letters received into the practice had not been actioned correctly. Following the investigations into this, some changes had been introduced to the scanning process to reduce the risk of this happening again.

The practice used the CCG-wide Safeguard Incident Reporting Management System (SIRMS) to record incidents and provide feedback on patient's experiences of care within other services in the local area.

We reviewed safety records, 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.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff including receptionists, administrators and nursing staff, were aware of the system for raising significant events. Incident forms were available on the practice intranet. We saw records were kept of significant events that had occurred. We looked at records of events recorded during the last 12 months. The number of recorded significant events was less than expected for the practice size, with three recorded since April 2014. Significant events were correctly actioned and investigated, but concentrated exclusively on negative events rather than also celebrating good practice and recording compliments. A GP we spoke with said they viewed positive outcomes as 'just doing your job' and these were not reported. There was one serious incident which had been correctly recognised and actioned by the practice in a timely manner to prevent recurrence. There was evidence of learning from recorded events which were discussed at clinical meetings. Overall the practice should endeavour to increase both the recording and learning from significant events.

National patient safety alerts were received into the practice electronically by the practice manager. The alerts were reviewed and sent to the appropriate staff for their attention. The practice also maintained an alerts log to record any alerts received and action taken in response. Staff we spoke with were aware of these systems and were able to give examples of recent alerts relevant to the care they were responsible for. Staff said alerts were also discussed at meetings to ensure they were aware of any relevant to their area of work and where action needed to be taken.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that most staff had received relevant role specific training on safeguarding. The practice nurses had completed level one training for safeguarding children and were booked onto level two training planned for October 2015. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out-of-hours. We saw contact details were easily accessible.

The practice had a dedicated GP partner appointed as the lead in safeguarding vulnerable adults and children. This person had been trained to child safeguarding level three

to enable them to fulfil this role. The other GPs had been trained to this level too. Staff we spoke with were aware of who the lead for the practice was and who to speak to if they had any safeguarding concerns.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, children subject to child protection plans.

A chaperone policy was in place and notices were displayed in the patient waiting area to inform them of their right to request one. Clinical staff and a number of trained administrative staff carried out chaperoning duties when patients requested this service. Non-clinical staff who carried out chaperone duties had not undergone a Disclosure and Barring Service (DBS) criminal record check or been risk assessed for this role. The practice manager assured us that non-clinical staff would not be used as chaperones in future, until the practice had completed a DBS check for them.

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

### Medicines Management

We checked vaccines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice had arrangements in place to ensure the 'cold chain' was maintained for the storage of vaccines and other medicines requiring refrigeration. This included when these vaccines and medicines were received into the practice. There was a process for checking medicines were kept at the required temperatures and this was being followed by the practice staff. This ensured the medicines in the fridges were safe to use.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. This included the supply of emergency medicines kept by the practice. Expired and unwanted medicines were disposed of in line with waste regulations.

There was a protocol for repeat prescribing which was followed in the practice to ensure that patients' repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and these were tracked through the practice and kept securely at all times.

### Cleanliness & Infection Control

We saw the premises were clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Regular checks on the quality of cleaning were completed; both by the practice staff and the contracted cleaning company. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead GP for infection control who was supported by one of the practice nurses (who was given protected time for this) and the practice manager. The designated nurse had undertaken further training to enable them to provide advice on infection control to the practice. All staff received induction training about infection control specific to their role, and thereafter updates were provided internally or at 'Time-Out' training sessions.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement infection control measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. Staff who worked on reception were able to describe the process to follow for the receipt of patient specimens. There was also a policy for needle stick injuries and the disposal and management of clinical waste.

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

Good

# Are services safe?

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

## Equipment

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

## Staffing & Recruitment

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

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There were arrangements in place for members of staff to cover each other's annual leave. The practice manager said the practice used three regular locum GPs to cover their GPs annual leave or absence.

Staff told us there was enough staff to maintain the smooth running of the practice and there was always enough staff on duty to ensure patients were kept safe.

## Monitoring Safety & Responding to Risk

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

Identified risks had been recorded and each risk was assessed with mitigating actions noted to manage the risk. We saw where risks had been identified; action plans had been drawn up to reduce these risks. For example, we saw fire risk and health and safety checklists had been completed within the last 12 months.

Staff were able to identify and respond to changing risks to patients, including deteriorating health and medical emergencies. For example, 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 staff had received training in basic life support. Emergency equipment was available. This included a defibrillator (used to attempt to restart a person's heart in an emergency) and oxygen. Records of checks of the defibrillator and the oxygen were up-to-date. All the staff we asked knew the location of this equipment.

Emergency medicines were available in a secure area of the practice and all the staff we spoke with knew of their location. Processes were 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 Planning And Recovery Toolkit' 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 and full loss of the practice's computer systems. A copy of this document was held by the practice manager and a GP partner kept a copy at home.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff we spoke with could describe the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE). We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs and these were reviewed when appropriate. For example, we were told that patients with long-term conditions were invited into the practice for blood tests and to have their medication reviewed for effectiveness.

GPs led in specialist clinical areas such as diabetes, asthma and sexual health and were supported by the practice nurses. GP leads had overall responsibility for ensuring the disease or condition was managed effectively in line with best practice. Nurses were jointly responsible with GPs for ensuring the day-to-day management of a disease or condition was in line with practice protocols and guidance. For example, the nurse who led on diabetes met weekly with the GP diabetic lead to review medication changes. Staff had access to the necessary equipment and were skilled in its use; for example, blood pressure monitoring equipment.

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 completed CQC comment cards.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with the clinical staff 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 unless there was a clinical reason for doing so.

### Management, monitoring and improving outcomes for people

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

The practice were able to show us some clinical audits that had been completed. We reviewed the examples of clinical audit the practice sent to us ahead of the inspection and asked for further examples during the inspection. There was evidence of audits having been undertaken which were relevant to individual clinical practice by some clinicians; however the majority of evidence presented were reviews (i.e. the first part of an audit), and there was limited evidence of completed audit cycles that included re-audits.

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

The practice was proactive in the management, monitoring and improving of outcomes for patients. For example, they used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. The Quality and Outcomes Framework is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually. The practice had achieved 99.3% of the points available in 2013/14, which included all of the points available for asthma, dementia and epilepsy.

The practice also had improvement plans in place. For example, the practice had done some work on comparing their performance on patient referrals compared to other practices within the local Clinical Commissioning Group (CCG) area. Overall, they were the second highest referrers across all specialities in the area. For three specialities (Dermatology, Urology and Cardiology) they were well above the benchmark for other practices in the area. The practice manager explained the cardiology figure was due to the fact the practice didn't do Electrocardiograms (ECG's) on site. An audit on a sample of patients who had been referred to Urology had already been completed in January 2015, and prior to that in May 2014. The results from

Good

# Are services effective?

## (for example, treatment is effective)

January 2015 showed 23 of the 24 referrals reviewed had been appropriate, with learning shared between GPs to reduce the likelihood of unnecessary referrals in future. The results of the audit in May 2014 showed that 18 of 19 referrals had been appropriate. A review of patients who had been referred to Dermatology was in progress.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up-to-date with attending mandatory courses such as annual basic life support. We saw plans were in place to update this training over the coming months. All GPs were up-to-date with their yearly continuing professional development requirements and all had been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list.)

Staff received appraisals which identified learning needs from which action plans were documented. The latest round of appraisals had been completed in 2013 for many of the staff; however staff we spoke with said they had dates booked in the next few weeks for their next appraisal. Records we saw confirmed this. The nursing team had received their appraisals more recently, in December 2014. One of the main objectives for the nursing team as a whole was to continue their training to allow them to do more chronic disease management. Staff we spoke with said the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were in training to be qualified as GPs had access to a senior GP throughout the day for support. Feedback from the trainee we spoke with was positive.

Nursing staff had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, they were trained to administer vaccines and immunisations and carry out reviews of patients with long-term conditions such as asthma and diabetes.

The administrative and support staff had clearly defined roles, however they were also able to cover tasks for their colleagues. This helped to ensure the team were able to maintain levels of support services at all times, including in the event of staff absence and annual leave.

### Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage patients with complex health conditions. Blood results, X-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service, were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers promptly and efficiently. All mail and test results were dealt with on the day they were received by staff working on that day. Any changes in medication or actions required were initiated by a clinician. In addition, if the requesting clinician needed to know about any borderline or abnormal results, then they were informed electronically by their colleague. This was an efficient system which ensured timely data entry and also meant that GPs did not have to pick up additional work on their return. All staff we spoke with understood their roles and felt the system in place worked well.

GPs told us they worked well together as a team. This included meeting informally on a daily basis between their morning and afternoon surgeries in the conference room while they dealt with incoming mail and test results. Weekly meetings for GPs were also held and were used to discuss cases, including any patients who were receiving palliative care.

The practice held multidisciplinary meetings on a regular basis to discuss the needs of high risk patients, for example, those with end of life care needs. These meetings were attended by a range of healthcare professionals, including district nurses and health visitors, and decisions about care planning were recorded. The practice's GPs and nurses attended these meetings and felt this system worked well. They remarked on the usefulness of the meetings as a means of sharing important information.

The practice also attended a number of local care homes on request, although there was no specific times or clinicians dedicated to this. Reviews for these patients were done opportunistically. If patient reviews weren't picked up through the recall system, a planned visit to the care home was made.

### Information Sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, for example, 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). Choose and Book appointments were made by the GP in conjunction with the patient in the GPs consulting room. Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times. The practice also shared relevant information, with the consent of their patients, with out-of-hour's services. Special patient notes could be added to the practice's electronic systems which were visible to the out of hour's service provider.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, 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 completed, both internally via e-learning and externally at the quarterly 'Time Out' training days run by the local Clinical Commissioning Group (CCG). All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. They also demonstrated an understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's formal written consent was obtained. Verbal consent was taken from patients for routine examinations. Patients we spoke with reported they felt involved in decisions about their care and treatment.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. Staff we spoke with gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All of these patients were offered two 30-minute review appointments; initially with a practice nurse, then with the GP once the initial blood test results had been received.

### Health Promotion & Prevention

The practice asked new patients to fill in a questionnaire when they registered with the practice. This included asking patients about any medicines they were taking and any chronic diseases or long term conditions they had. The practice did not offer a special appointment to all patients for an initial health check on registration. On completion of the questionnaire, the patient's needs were assessed and where appropriate, they were placed into the relevant monitoring service. For example, children would be placed within the immunisation programme at the appropriate point.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for immunisations was in line with averages for the Clinical Commissioning Group (CCG). For example, Hib/Men C Booster vaccination rates for five year old children were 90.1% compared to 93.9% across the CCG; and MMR Dose 2 vaccination rates for five year old children were 94.5% compared to 92.7% across the CCG.

We found patients with long-term conditions were recalled to check on their health and review their medicines 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. This was supported by the practice achieving 99.3% of the QOF points available in 2013/14, which included rewarding practices for managing some of the most common long-term conditions. Processes were also in place to ensure the regular screening of patients was completed, for example, cervical screening. Cervical screening rates for women aged 25-64 were well above the national average at 91.4%, compared to 81.9% nationally. The practice manager said they sent a second invite letter out to their eligible patients if they didn't respond to the first letter sent out to them by the NHS Cervical Screening Programme. They felt this may contribute to their higher than average performance.

Good

# Are services effective?

## (for example, treatment is effective)

There was a range of information on display within the practice reception area. This included a number of health promotion and prevention leaflets, for example, on cervical screening, strokes and stopping smoking. The practice's website included links to a range of patient information, including for the management of long term conditions such as cancer and coronary heart disease (CHD).

Good

# Are services caring?

## Our findings

### Respect, Dignity, Compassion & Empathy

Patients we spoke with said they were treated with respect and dignity by the practice staff. Comments left by patients on Care Quality Commission (CQC) comment cards mostly reflected this. Of the 17 CQC comment cards completed, 13 patients made direct reference to the caring manner of the practice staff. Words used to describe the approach of staff included helpful, kind, understanding, friendly, polite, caring and respectful.

We observed staff who worked in the reception area and other staff as they received and interacted with patients. Their approach was considerate and caring, while remaining respectful and professional. This was appreciated by the patients who attended the practice. We saw that any issues raised by patients were handled appropriately and the staff involved remained polite and courteous at all times.

The reception area fronted directly onto the patient waiting area. We saw staff who worked in these areas made every effort to maintain patients' privacy and confidentiality. Voices were lowered and personal information was only discussed when absolutely necessary. We were told a separate room was made available to patients if they wanted to speak about matters in a more private setting. This reduced the risk of personal conversations being overheard. Phone calls from patients and other healthcare professionals were taken by administrative staff in a separate area where confidentiality could be maintained.

Patients' privacy, dignity and right to confidentiality were maintained. For example, the practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination. We spoke with clinical staff about how they maintained privacy and dignity for their patients, for example during intimate examinations. They gave good descriptions of the measures they took, including the use of curtains to allow patients to undress in private and the use of paper roll to allow patients to cover themselves and make them feel more at ease.

Staff were aware of the need to keep records secure. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation. Staff had completed information governance training and this was updated annually.

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, 84% of respondents said the last GP they saw or spoke to and 88% said the last nurse they saw or spoke to was good at involving them in decisions about their care. Both these results were better than the local Clinical Commissioning Group (CCG) area averages, which were 83% and 68% respectively.

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 informed decisions about the choice of treatment they wished to receive. Patient feedback on the CQC comment cards we received was also mostly positive and supported these views. Two of the 17 CQC comment cards we received indicated these patients were less satisfied with the care and treatment they had received.

The practice had identified its most at risk and vulnerable patients. A total of 156 patients had been identified as being at high risk of hospital admission. The practice had contacted these patients and with their involvement and agreement, had put agreed care plans in place. These care plans were reviewed after 3 months to make sure they still met the needs of the patients. Each of these patients were identified on the practice's electronic system. The practice manager said the practice aimed to have at least 161 patients with agreed care plans in place by the end of March 2015.

Staff told us that translation services were available for patients who did not have English as a first language. Support was also available for patients with hearing difficulties and access to a sign language service was

Good

# Are services caring?

advertised in the patient waiting area. We saw a patient attended the practice for an appointment with an interpreter on the day of the inspection. Both the patient and their interpreter were seen to be using sign language.

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

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

Notices in the patient waiting room signposted patients to a number of support groups and organisations. The practice maintained a carer's register and had 104 patients registered. The practice manager said they were still verifying this information to ensure it was accurate; for example to ensure people employed as care workers were not included. The practice's computer system alerted GPs if a patient was also a carer. They were proactive in trying to identify patients with caring responsibilities. Patients who registered with the practice were asked if they had any caring responsibilities.

Support was provided to patients during times of need, such as those in receipt of end of life care and in the event of bereavement. The practice had a GP lead for palliative care, however the GPs we spoke with said in practice all GPs would support individual patients until their death. Bereavement cards were sent to families when appropriate, based on the relationships and involvement the family had with their relatives GP. Staff we spoke with in the practice recognised the importance of being sensitive to patients' wishes at these times.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

Patients we spoke with and those who filled out Care Quality Commission (CQC) comment cards mostly said they felt the practice was meeting their needs. This included being able to access repeat medicines at short notice when this was required.

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. For example, patients had asked for the ability to book longer appointments if they needed them to be able to discuss more than one problem with their GP. This facility had been put into place. The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Staff we spoke with said patients were encouraged to see the same GP if possible, which enabled good continuity of care. Patients could access appointments face-to-face in the practice, receive a telephone consultation with a GP or be visited at home.

The practice engaged regularly with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. One of the GPs was a practice board member for the local CCG and attended CCG meeting updates and participated in decision making in this capacity on a regular basis. They described to us how there had been some initial interest in standardising community nursing services across different practices in the area, however they felt this had stagnated lately.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients and their families' care and support needs. The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment.

The practice had an active patient participation group (PPG) and met with them on a quarterly basis. They had implemented suggestions for improvements and made changes to the way they delivered services in response to feedback from the PPG. We spoke with two members of the group who both said they felt the practice listened and responded to any concerns they raised. For example, both group members mentioned they had raised how difficult it could be to get through on the telephone when the practice first opened in the morning. In response, they had increased the number of staff on the phone on opening in the morning and the number of telephone lines available.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, opening times had been extended to provide evening appointments on Mondays until 8.00pm. Patients could see either a GP or a practice nurse at the Monday evening surgery. This helped to improve access for those patients who worked full time. The practice also had access to translation services if required, for those patients whose first language was not English. The practice maintained registers for patients with caring responsibilities, patients with learning disabilities and patients receiving palliative care. All of these measures helped to ensure that all of their patients had equal opportunities to access the care, treatment and support they needed.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and this was updated on a regular basis.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was situated on the ground and first floors of the building with the majority of services for patients on the ground floor. If patients needed to access the first floor, a passenger lift was available to use. The practice manager said patients were always accompanied to and from the first floor by a member of staff. We saw this happen on the day of the inspection.

The main entrance door had been automated to improve access and all of the treatment and consulting rooms could be accessed by those with mobility difficulties. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. This made movement around the practice easier and helped to maintain patients' independence. The patient toilets could be accessed by patients with disabilities. Dedicated car parking was provided for patients with disabilities in the practice car park at the rear of the practice. An induction loop system was in place for patients who experienced hearing difficulties.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

The practice had an active patient participation group (PPG) and the group had representation from a diverse cross section of the local community. This included younger people, older people, professionals, people from minority groups and people whose circumstances may make them vulnerable. This helped to ensure that the needs of different groups were able to be heard and considered in the planning and delivery of services.

### Access to the service

The National GP Patient Survey information we reviewed showed the patients who responded were less satisfied with access to the service compared to other practices within the local Clinical Commissioning Group (CCG) area. For example, 59% of respondents said they found it easy to get through to the surgery by phone, compared to the local CCG average of 84%. Only 82% of respondents said they were able to get an appointment to see or speak with someone the last time they tried, compared to the local CCG average of 85%. Finally, 57% of respondents described their experience of making an appointment as good, compared to the local CCG average of 78%.

Most of the patients we either spoke with, or who filled out Care Quality Commission (CQC) comment cards, said they were satisfied with the appointment systems operated by the practice. Four of the 17 patients who filled in CQC comment cards were not as satisfied. They made comments such as 'appointments are a little difficult to arrange', 'only concern is booking appointments, never any available' and 'the appointment system does need improving.' Eight of the 17 patients we spoke with mentioned they had experienced some difficulty in getting an appointment at short notice. We mentioned this to the practice manager and GPs, who said this feedback would be included as part of the on-going review of the appointments system.

The practice had completed its own survey of patients in October 2014, where access to appointments had been noted as a concern. In response, they had done some analysis of appointment availability and discussed this at a GP partners meeting in November 2014. A number of actions were agreed in an attempt to improve access for patients, for example a reduction in the number of 'catch up slots' during afternoon surgeries.

Appointments were available from 8.30am Monday to Friday and until 5.00pm Tuesday to Friday. On Monday evenings, appointments were available with a GP or practice nurse until 8.00pm. Some analysis of the practice's appointments system in November 2014 showed over 400 face to face appointments were made available to patients each week. Telephone consultations with GPs could also be booked each day. The practice's extended opening hours on Monday evenings were particularly useful to patients with work commitments. This was confirmed by patients we spoke with who worked during the week.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a GP or nurse. Home visits were made to those patients who needed one.

Information was available to patients about appointments on the practice website. This included being able to book appointments with GPs online and information on how to arrange appointments and home visits.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The service for patients requiring urgent medical attention out-of-hours was provided by the 111 service and Northern Doctors Urgent Care Limited.

Patients with no fixed abode were welcomed into the practice and could register with them the same as any other patients. Although the number of these patients registered with the practice was low, they had made arrangements to allow them to collect any correspondence, for example from hospitals, from the practice itself.

### Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Information about services and how to complain was available and easy to understand.

We saw the practice had received six complaints since April 2014 and these had been investigated. The practice's complaints policy stated 'We shall acknowledge your complaint within 2 working days'; however the records we looked at showed this had not always happened. For

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

example, it took the practice 17 days to respond to a complaint received in October 2014. An apology had been given to the complainant for this delay. 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 partners and staff meetings.

Staff we spoke with were aware of the practice's policy and knew how to respond in the event of a patient raising a complaint or concern with them directly.

None of the patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice before. In addition, none of the 17 CQC comment cards completed by patients indicated they had raised a complaint with the practice.

# 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 aimed to provide the highest quality healthcare to patients in the Newcastle area. Their statement of purpose included seven stated aims and objectives. These included 'To provide high quality primary care to our patient population' and 'To treat patients as individuals and with the same respect we would want for ourselves or a member of our families.' The practice manager said the practice did not have a formal business plan as such yet; however we were told the GP partners had started to meet outside the practice to discuss forward planning.

We spoke with a variety of practice staff including the practice manager, three GPs, an F2 foundation doctor, three practice nurses, a health care assistant and some of the practice's administrative and support staff. They all said meeting the needs of their patients was their priority and knew what their responsibilities were in relation to this.

### Governance Arrangements

The practice had policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked a sample of these policies and procedures and staff we spoke with knew how to access them. All of the policies and procedures we looked at had been reviewed regularly and were up to date.

The practice used the Quality and Outcomes Framework (QOF) as a means to measure its performance. The QOF data for this practice showed it was performing above national standards. We saw that QOF data was regularly discussed at practice meetings and actions were taken to maintain or improve outcomes. For example, the practice had recently purchased a software package to interrogate their patient records to help with the identification of patients with long term conditions.

The practice manager regularly used benchmarking to monitor the performance of the practice in comparison to other practices. This included practices within the local Clinical Commissioning Group (CCG) area, for example on referral rates to other services.

The practice had completed a number of clinical audits which it used to monitor quality and systems to identify where action should be taken. Not all of the clinical audits completed measured whether agreed standards had been achieved or made recommendations and took action where standards were not being met.

The practice had arrangements for identifying, recording and managing risks. We saw that risks were regularly discussed at practice meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and actions to mitigate these risks had been put into place.

The practice held regular partners meetings and management meetings. Partners meetings had been planned for the whole of 2015/16, with regular reviews of QOF performance, Friends and Family Test results and patients at risk of re-admission to take place throughout the year. We looked at minutes from some of these meetings and found that performance, quality and risks had been discussed.

### Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, there was a GP partner and lead nurse for infection control and a GP partner was the lead for safeguarding. We spoke with a range of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We found there were good levels of staff satisfaction. Staff we spoke with were proud of the organisation as a place to work and spoke of the open and honest culture. There were good levels of staff engagement. We saw from minutes that team meetings were held regularly. Staff told us they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example on recruitment and infection control, which were in place to support staff. We saw policies were available for all staff to access electronically. Staff we spoke with knew where to find the practice's policies if required.

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

The practice had gathered feedback from staff through staff meetings and informal discussions on a daily basis. Staff we spoke with told us they regularly attended staff

# Are services well-led?

Good

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

meetings, including within their own work areas and wider practice 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 manager and GPs told us forward planning was an area they had identified for improvement. The practice did not have a formal business plan as such yet; however we were told the GP partners had started to meet outside the practice to discuss forward planning.

The practice had an active patient participation group (PPG). The PPG contained representatives from a wide range of population groups. The PPG met every quarter and representatives from the practice always attended to support the group. We spoke with some members of the PPG and they felt the practice supported them fully with their work and took on board and reacted to any concerns they raised. For example, the practice had made some changes as a result of feedback from the PPG. This included changes made to staffing first thing in the morning in an attempt to improve access for patients calling the practice for same-day appointments. Patient feedback was also routinely reviewed at group meetings, including any actions taken by the practice in response.

The practice also sought feedback from patients by completing its own patient surveys; the most recent of which was completed in October 2014. The survey focused on the 'Friends and Family' style questionnaire that would be formally introduced in December 2014. Of the 155 surveys completed, 144 (92.9% of respondents) said they were likely or extremely likely to recommend the practice. Even though this feedback was largely positive, a number of actions had been agreed with the practice's PPG. The practice had also started to analyse their actual friends and family test results, which was introduced into general practice in December 2014. Results from feedback received in January 2015 showed 21 of 23 (91.3%) patients who responded said they were likely or extremely likely to recommend the practice. The average score awarded to the practice by the 23 respondents was 4.5 out of 5 stars.

The practice manager said they had not pro-actively asked stakeholders for feedback; however they had received some mixed feedback from local chemists about the speed of issue of prescriptions. They said they had met with them with the aim of resolving the issues raised. None of the patients we spoke with raised any concerns on this matter.

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 & improvement

The practice was a GP training practice and we spoke with an F2 foundation doctor (a fully qualified doctor allocated to the practice as part of a two-year, general postgraduate medical training programme) who had recently joined the practice. They told us they felt involved in the work of the practice and well supported by the GP who supported them directly and by the other GPs and clinical staff at the practice.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The practice nurses we spoke with all said the GPs were very supportive with their on-going professional development. We saw that appraisals were planned and had taken place which included a personal development plan. Staff told us that the practice was 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.

GPs at the practice met informally on a daily basis in the conference room. This provided them with the opportunity to discuss and share learning from both clinical and operational issues. For example, clinical issues could include palliative care management, serious incidents, patient access and any queries they had on case management. GPs met with colleagues at locality and

# Are services well-led?

Good

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

Clinical Commissioning Group (CCG) meetings. They attended learning events and shared information from these with the other GPs in the practice. Clinicians regularly fed back to their colleagues after attending educational meetings and CCG-led 'Time Out' training events. Nursing staff we spoke with said they attended a monthly CCG-wide practice nurse forum which provided them with further education and support. The nurse who led on diabetes also attended a diabetic nurse forum which was also attended by diabetic nurses who worked in hospitals. This helped to provide specific support for their management of patients with this long term condition.