Dr Bannatyne & Partners

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
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 Dr Bannatyne and Partners on 11 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective and responsive services and for being well led. It was outstanding for providing caring services. It was also good for providing services for all the population groups.

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.
- Systems were in place to monitor safety and respond to risk.
- Risks to patients were assessed and well managed.
- Medicines were safely managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Feedback from people who use the service and stakeholders was continually positive about the way staff treated people. The majority of comments from patients were extremely positive about the service patients experienced. Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Some patients said they would have to wait for a routine appointment and to see a GP of choice. Emergency appointments were always available.
- Patients told us they never felt rushed in their appointment. Records showed the practice had increased the flexibility and length of time from 10 minutes for their GP appointments to 12 minutes and 15 minutes for the duty doctor.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

- The practice had identified their vision which was promoted throughout the practice.
- There was an effective governance framework, which focussed on delivering good quality care.

We saw several areas of outstanding practice including:

- Staff recognised patients emotional and social needs were as important as their physical needs. Staff provided us with many examples and we saw evidence to show how patients were supported emotionally with their care and treatment. For example GPs had offered and had taken patients to hospital appointments when they required help and support emotionally with their care and treatment.
- When patients with a learning disability were recalled to the practice for a health check, they were sent a specific questionnaire in an easy read format for the patient to complete and a questionnaire for their carer if deemed appropriate. Patients and carers were encouraged to bring these to their appointment. Appointments were confirmed via the telephone to ensure the correct person had been made aware of the appointment.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, reviewed and addressed. Risks to patients were assessed and well managed. Medicines were well managed and there were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence 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. There was evidence of appraisals and personal development plans for all staff. Staff had well established links and met regularly with multidisciplinary teams.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services.

Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from people who use the service and stakeholders was continually positive about the way staff treated people. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care. We found many positive examples to support this.

Staff were fully committed to working in partnership with patients. They always considered patients personal, cultural, social and religious needs and recognised patients emotional and social needs were as important as their physical needs.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they could mostly access an appointment when they

Summary of findings

needed to although access to a named GP was not always easy within a short timeframe. The practice had increased the flexibility and length of time from 10 minutes for their GP appointments to 12 minutes and 15 minutes for the duty doctor.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

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

It had a clear vision and strategy which was regularly reviewed, discussed with staff and advertised in the practice. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. There was an effective governance framework, which focussed on delivering good quality care. Effective and comprehensive processes were in place to identify, understand, monitor and address current and future risks. Clinical and internal audit processes functioned well and had a positive impact in relation to quality governance, with clear evidence of action to resolve concerns. The practice proactively sought feedback from staff and patients, which it acted on. A virtual patient participation group (PPG) was in place. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. All patients over 75 years had a named GP. The practice provided weekly visits to four care homes by a named GP.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Staff had a good understanding of the care and treatment needs of these patients and staff had lead roles in chronic disease management. The practice closely monitored the needs of this patient group. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met. There was a recall programme in place to make mitigate the risk of patients missing their regular reviews for conditions, such as diabetes, respiratory and cardiovascular problems. We heard from patients that staff invited them for routine checks and reviews. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Staff were skilled and regularly updated in specialist areas which helped them ensure best practice guidance was being followed.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us children and young people were treated in an age-appropriate way and were recognised as individuals. We saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good

Summary of findings

examples of joint working with the community health visiting team. The practice provided a range of contraceptive, pre-conceptual, maternity and child health services with some clinical staff holding specific qualifications in these areas.

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 offered extended opening hours twice a week. Telephone appointments were also available. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

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 homeless people, travellers and those with a learning disability. The practice had care plans in place for 4% of their population who were vulnerable or at risk of unplanned admission. Systems were in place to ensure a care plan was put in place as soon as a patient was identified by the GP as being vulnerable. Longer appointments were available for patients who required them.

The practice held regular monthly multi-disciplinary meetings where vulnerable patients including those on the unplanned admissions register were reviewed. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 91% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice participated in shared care arrangements for monitoring patients on certain medicines.

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including dementia forward, MIND and Harrogate advocacy service. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with six patients who were using the service on the day of our inspection and reviewed 43 completed CQC comment cards. We spoke with a member of the PPG. The majority of feedback we received was positive. Staff were described as excellent, caring, prompt, courteous, supportive, efficient and outstanding. Patients said they were well cared for and listened to. The very small number of negative feedback related to access to appointments and to a named GP. The majority of feedback showed getting an appointment was easy and the practice was timely with any treatment.

The GP Patient Survey results (an independent survey run by Ipsos MORI on behalf of NHS England) published on 8 January 2015 showed the practice scored above 90% in 15 out of the 27 questions.

What this practice does best when compared to the CCG and national average

97% of respondents say the last nurse they saw or spoke to was good at giving them enough time

Local (CCG) average: 93% National average: 92%

98% of respondents say the last GP they saw or spoke to was good at listening to them

Local (CCG) average: 94% National average: 89%

95% of respondents say the last GP they saw or spoke to was good at giving them enough time

Local (CCG) average: 93% National average: 87%

What this practice could improve when compared to the CCG and national average

75% of respondents find it easy to get through to this surgery by phone

Local (CCG) average: 89% National average: 73%

48% of respondents with a preferred GP usually get to see or speak to that GP

Local (CCG) average: 62% National average: 60%

73% of respondents describe their experience of making an appointment as good

Local (CCG) average: 84% National average: 73%

There were 281 survey forms distributed for Dr Bannatyne & Partners and 124 forms were returned. This is a response rate of 44.1%. This equates to 1.1% of the practice population.

We looked at the results of the Friends and Family Test for February, March and April 2015. Of the 108 responses received, 92% were extremely likely or likely to recommend the practice to family or friends. 5% were extremely unlikely or likely to recommend. 3% were neither. The feedback to support this data was extremely complimentary about the care and support patients received. The negative comments mostly related to appointments.

Outstanding practice

- Staff recognised patients emotional and social needs were as important as their physical needs. Staff provided us with many examples and we saw evidence to show how patients were supported emotionally with their care and treatment. For example GPs had offered and had taken patients to hospital appointments when they required help and support emotionally with their care and treatment.
- When patients with a learning disability were recalled to the practice for a health check, they were sent a specific questionnaire in an easy read format for the patient to complete and a questionnaire for their carer if deemed appropriate. Patients and carers were encouraged to bring these to their appointment. Appointments were confirmed via the telephone to ensure the correct person had been made aware of the appointment.

Dr Bannatyne & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector who was shadowed by a CQC inspector. The team included two CQC specialist advisors; a GP and a pharmacist.

Background to Dr Bannatyne & Partners

Dr Bannatyne & Partners, 54 Church Avenue, Harrogate, HG1 4HG is situated in Harrogate. There is a branch practice at Winksey Cottage, High Street, Hampsthwaite. The branch practice dispenses medicines to registered dispensing patients. The registered patient list size of the practice is 11,165 covering approximately 100 square miles. The overall practice deprivation is on the eighth least deprived decile. Deprivation is 11% less than the national England average. There is a mix of male and female staff at the practice. Staffing at the practice is made up of five GP partners, two salaried GPs, two GP registrars, two advanced nurse practitioners, four practice nurses and one phlebotomist. There was a team of administrators, receptionists and dispensers as well as a practice and deputy practice manager, premises and information technology manager and a dispensary manager.

The practice offered appointments at the main practice from 08:00 to 18:00 Monday to Friday. Evening appointments were available on a Monday and Thursday from 18:30 to 20:00. The branch practice opened on a Monday from 09:00 to 18:00, Tuesday from 08:00 to 12:30, Wednesday from 10:00 to 13:00, Thursday from 09:00 to 12:30 and Friday from 08:30 to 12:30. When the practice is closed an out of hours service is provided between 18:00 to 18:30 by Primecare who triage calls. The out of hours service provided between 18:30 and the following 08:00 and at weekends is provided by Harrogate District Foundation Trust.

The practice has a general medical service (GMS) Contract under section 84 of the National Health Service Act 2006.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act as part of our regulatory functions. This inspection was planned to check whether the provider was 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 CQC at that time.

How we carried out this inspection

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

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

Detailed findings

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

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

Before our inspection we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We asked Harrogate and rural CCG to tell us what they knew about the practice and the service provided. We reviewed some policies and procedures and other information received from the practice prior to the inspection.

We carried out an announced inspection on 11 June 2015. We inspected the main practice and the dispensary at the branch practice. During our inspection we spoke formally with 14 members of staff. This included three GP partners, a GP registrar, the advanced nurse practitioner, two practice nurses, the practice manager, medicines manager and five administrators. We also met with the chair of the PPG and met with external professionals such as district nurses and health visitors who were attending the monthly multidisciplinary meeting. We also spoke to six patients who attended the service that day for treatment. We reviewed comments from 43 CQC comments cards which had been completed.

We observed interaction between staff and patients in the waiting room.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients, staff and other professionals. Evidence showed the practice had managed these appropriately.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. 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 show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We looked at records of significant events that had occurred during the last twelve months; other years were available. Significant events were discussed monthly at practice meetings or sooner if needed. The practice had introduced a quarterly review of significant events to complement the annual review to improve the reviewing arrangements. There was evidence the practice had learned from these and the findings were shared with relevant staff. All staff knew how to raise an issue for consideration at the meetings and were encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We looked at the significant event records and saw evidence of action taken as a result. For example the practice had amended their policy in relation to the disposal of needles and the emergency medicines that should be available at the practice. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. The practice offered to meet with patients where this was deemed appropriate.

The practice had devised a 'never list' that was displayed within the practice and formed part of the practice's mission statement. The list was composed after discussion with staff and following published research. The list detailed incidents that should never happen and what measures the practice had put in place to prevent such incidents occurring.

Arrangements were in place to ensure National patient safety alerts were disseminated to staff. . Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that not all staff had received relevant role specific training on safeguarding adults. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had an appointed dedicated GP lead in safeguarding vulnerable adults and children. They had been trained to enable them to fulfil this role. All staff we spoke with were aware of who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The practice had well established arrangements to meet with other professionals as part of the multidisciplinary meetings on a regular basis.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Reception staff would act as a chaperone if required. We identified that not all these staff had a DBS check. Arrangements to rectify this arrangement were put in place immediately.

Good

Are services safe?

Medicines management

The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. The practice was signed up to the Dispensing Services Quality Scheme (DSQS) to help ensure processes were suitable and the quality of the service was maintained. Dispensing staff had all completed appropriate training and had their competency annually reviewed.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again. We saw processes in place for managing national alerts about medicines such as safety issues. Records showed the alerts were distributed to relevant staff and appropriate action taken.

There was a clear system for managing the repeat prescribing of medicines. Dispensary staff controlled the ordering and supply of repeat prescriptions and the GP's oversaw this. Patients could order their medicines on-line, by email or by post. We found repeat prescriptions were not dispensed and supplied to patients before they were signed by the GP – in fact nothing could be dispensed to the patient unless it had been checked by the prescriber and both the label and the prescription were signed. Changes in patients' medicines, for example when they had been discharged from hospital, were checked by the GP who made any necessary amendments to their medicines records. Medicines not prescribed by the practice such as those prescribed in secondary care were recorded on the patient's records but did not form part of the current medicines list. There was a robust process for ensuring compliance and prompt review of all medicines particularly high risk drugs such as warfarin.

We checked the dispensary; treatment rooms, medicine refrigerators and GPs' bags and found medicines were safely stored with access restricted to authorised staff. Excellent procedures were in place for ensuring medicines that required cold storage were kept at the required temperatures.

Stocks of controlled drugs (medicines that have potential for misuse) were managed, stored and recorded properly following standard written procedures that reflected national guidelines. Processes were in place to check medicines were within their expiry date and suitable for use. Out of date and unwanted medicines were disposed of in line with waste regulations. Vaccines were administered by nurses who were suitably trained.

Blank prescription forms and paper were handled according to national guidelines and were kept securely. However there was no audit trail of numbers for the pads stamped with the Dr's name.

Cleanliness and infection control

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

The practice had a lead for infection control that was trained to enable them to carry out this role. All staff received induction training about infection control specific to their role although not all staff had completed infection control training. We saw evidence that regularly audits were carried out and reviewed to monitor that improvements identified for action were completed on time. Record showed the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. 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 to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Good

Are services safe?

Equipment

Staff we spoke with told us they had 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 evidence that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment for all permanent staff. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). When employing locums the practice did not always carry out their own checks but relied on the checks being carried out by the locum agency.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Records showed staffing levels were kept under review and discussed. The practice had recently introduced a staff training and skills matrix to support the monitoring of levels, training and staff skills. Arrangements had been put in place to ensure two members of staff were skilled in the same area to ensure adequate cover was available. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Monitoring safety and responding to risk

The practice had clear systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. Staff had lead roles to facilitate these processes. Examples included checks on both the buildings, the environment (internal and external), 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 to see and there was an identified health and safety representative.

Identified risks were recorded on a range of individual risk assessments. Records showed each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that control measures were put in place in response to identified risk. For example, following an incident the practice had reviewed what emergency medicines they had access to in treatment rooms where vaccines were administered. They had put measures in place to mitigate the risk of such an incident occurring in the future.

Arrangements to deal with emergencies and major incidents

Risks associated with service and staffing changes (both planned and unplanned) were discussed at practice meetings. The practice had arrangements in place to manage emergencies. Records showed that not all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia Processes were also in place to check whether emergency medicines, within the practice and GP bags were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Arrangements were in place to ensure medicines stored within GP bags were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

Good

Are services safe?

The practice had carried out fire risk assessments at both practices. The practice showed that where risk had been identified that control measures had been put in place. The practice carried out regular fire drills. Records showed that not all staff were up to date with fire training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

GPs and nurses lead in specialist clinical areas such as diabetes, heart disease and asthma. The nurse practitioners were able to see more complex patients, such as those with two or more chronic diseases. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of suspected cancers referred and seen within two weeks. Data provided by the CCG showed the practice was not an outlier for making two week referrals. The practice made referrals to a central management team managed by the CCG. (The referrals are triaged by clinical staff and then either accepted or returned to the practice for them to reconsider the referral). Staff reported this system worked very well for the practice and allowed them to reflect on any referrals returned. Staff told us they rarely received referrals back from the central team for reconsideration.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. Examples included recalling patients for clinical reviews, medicines management, referrals, information technology and seeing patients with long term conditions.

The practice had a system in place for completing clinical audit cycles. The practice showed us a range of clinical audits that had been completed in the last 24 months. We looked specifically at four of these. The first related to data the practice had received from the CCG which identified they were high prescribers of a certain medicine. The resulting audit showed substantial improvement but noted that as opiate prescribing remained an issue the practice would revisit again in 12 months. Other audits we looked at showed following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding a medicine used for some complaints of the stomach a clinical audit was carried out. The audit identified the patients taking the medicine, and patients were offered alternatives.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF) and we saw evidence to confirm this. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). The practice was not an outlier for any QOF (or other national) clinical targets.

Good

Are services effective?

(for example, treatment is effective)

The team was making use of clinical audit tools, clinical supervision, and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. For example nursing staff and the practice manager attended practice nurse and practice manager forums within the area. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice was following the gold standards framework for end of life care. It had a palliative care register and had regular monthly multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example the practice looked at prescribing rates and had taken action to address performance.

The practice provided a wide range of enhanced services. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). Examples include extended hours access, avoiding unplanned admissions and minor surgery. The practice provided 4% of patients at risk of unplanned admissions to hospital with an individualised care plan. This was part of the unplanned admissions Enhanced Service (ES) that the practice had signed up to. The ES had been introduced as part of a move to reduce unnecessary emergency admissions to secondary care. The main work of the ES is the proactive case management of at-risk patients which required coverage of 2% of the practice population over 18 years of age. The practice had systems and identified leads in place to deliver and monitor its performance against the enhanced services and we saw completed data returns to the CCG to demonstrate the delivery of enhanced services.

Effective staffing

Practice staffing included medical, nursing, managerial, dispensing and administrative staff. We reviewed staff training records and saw that not all staff had completed mandatory courses such as basic life support and infection control. The practice had a very good skill mix which included advanced nurse practitioners (ANPs) and was able to see a broader range of patients than the practice nurses. We noted a good skill mix among the GPs, with a range of additional diplomas amongst them. GPs had additional diplomas in a range of areas; examples of which were Royal College of Obstetricians and Gynaecologists (DRCOG), the Diploma of the Faculty of Sexual and Reproductive Healthcare (DFSRH) and The Diploma in Occupational Medicine (Dip.in OCC). Nursing staff also had a range of additional qualifications, for example RN Bsc (Hons) Nursing, MSc Prof. Studies (Nursing) and PG Dip Nurse Practitioner studies. Records showed staff were qualified and had the skills required enabling them to carry out their roles effectively and in line with best practice. The practice had recently introduced new systems for monitoring training and skill mix of staff to ensure that all staff had completed the required training. Systems were also in place for testing staffs knowledge in a range of areas at various times throughout the year. For example we saw quizzes were used to test staffs knowledge.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and 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 practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant

courses. Staff had protected learning time and attended meetings with their peers in the area. We received positive feedback from the trainee we spoke with regarding the quality of the training and support they received.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology Those with extended roles, for example prescribing medicines and seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease) were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service 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 on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients. For example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, and palliative care nurses. Decisions about care planning were documented in a shared care record. We spoke with members of the multi-disciplinary team who were attending the monthly meeting at the practice. They told us of the proactive and positive relationship with the practice. They were extremely complimentary about the practice and their multidisciplinary working arrangement.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making and receiving referrals.

Patients could access their summary care record on line. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. A wide range of staff had key roles in maintaining and ensuring system information was kept under review, was up to date and passed to the relevant staff in a timely way. Clear systems were in place for sharing any information with staff that was received into the practice. We saw evidence of regular information sharing between the practice and the CCG. For example practices received a weekly practice dispatch from the CCG which was circulated to all staff. Well established lines of communication were in place with other healthcare professionals and local care homes.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. 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. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with dementia were supported to make decisions through the use of care plans. Not all patients with a learning disability had a care plan in place although they were recalled to the practice for health reviews. When interviewed, staff 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 clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to

Good

Are services effective?

(for example, treatment is effective)

make their own decisions and to understand the implications of those decisions).There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures.

Health promotion and prevention

The data we looked at showed the practice performed well in the areas relating to health prevention. The GPHLI showed the practices' performance in a range of health prevention areas was at or slightly above the national average and did not present a risk. For example, diabetes retinal screening and blood pressure monitoring, cervical smears and health checks for mental illness were above the national average

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and mental ill health. A register of carers was also kept. Data from GPOS showed the practice's performance in a range of areas was mostly at or slightly above the national average in most areas. The practice had a comprehensive system in place which ensured that patients were recalled to the practice to have their health and medicines reviewed at the required times. We noted a culture among the GPs and nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Patients were followed up if they had risk factors for disease identified at the health check.

The practice offered a full range of immunisations for children, travel vaccines (including yellow fever) and flu vaccinations in line with current national guidance. Last year's performance for the childhood immunisations scheme was mostly slightly above the CCG average. The practice had a clear policy for following up non-attenders by the named practice nurse. The practice provided a range of contraceptive, pre-conceptual, maternity and child health services with some clinical staff holding specific qualifications in these areas.

There was a wide range of health promotion information in the waiting room and on the practice web site. There were posters around the practice. There were also specific areas in the waiting rooms dedicated to raising awareness for specific health issues, such as cervical cancer.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Evidence from all the sources we looked at showed patients were satisfied with the way they were treated and that this was with compassion, dignity and respect. 100% of respondents to the national GP patient survey said they had confidence in the last GP and nurse they spoke to. The national GP patient survey showed 93% said the last GP and 95% said the last nurse they saw or spoke to was good at treating them with care and concern and 95% said the GP and 97% said the last nurse they saw or spoke to was good at giving them enough time. All these results were above the CCG and national average.

Feedback from people who use the service and stakeholders was continually positive about the way staff treated people. The majority of comments from patients were extremely positive about the service patients experienced. Staff were described as excellent, caring, helpful, supportive and outstanding. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients told us they never felt rushed in their appointment. People told us staff were extremely compassionate to the patients and provided us with many examples to demonstrate this. They told us staff went the extra mile. Staff demonstrated they recognised and respected the totality of people's needs. They demonstrated they took account of patient's personal, cultural, social and religious needs. For example, as part of the multi-disciplinary arrangements the practice and health visitors worked together to identify patients 'of concern'. These were patients who were experiencing challenging personal circumstances which were not always health related that the practice and multi-disciplinary may need to be aware of. For example, patients who were experiencing fractured family relationships.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. The practice clearly advertised the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The 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, data from the national patient survey showed 86% of practice respondents said the GP and 86% said the nurse involved them in care decisions and 94% felt the GP and 90% was good at explaining treatment and results. All these results were mostly equal to the CCG and national average.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. 100% of respondents to the patient survey said they had confidence in the last GP and nurse they spoke to.

We saw evidence the practice encouraged patients who used the service to be active partners in their care. For example when patients with a learning disability were recalled to the practice for a health check, they were sent a specific questionnaire in an easy read format for the patient to complete and a questionnaire for their carer if deemed appropriate. Patients and carers were encouraged to bring these to their appointment. Appointments were confirmed via the telephone to ensure the correct person had been made aware of the appointment.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. 93% of the

Outstanding ☆

Are services caring?

respondents to the national GP patient survey said the GP and 95% said the last nurse they saw or spoke to was good at treating them with care and concern. These results were above the CCG and national average. The patients we spoke with on the day of our inspection and the comment cards we received were aligned with this information. Of the 63 responses to the Friends and Family Test in March 2015, 48 were extremely likely to recommend the practice. The individual comments referred to how well patients were treated and supported.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer and information was made available to support carers.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. The practice had a system in place to notify any healthcare services the patient was known to have been involved with. We were provided with examples to demonstrate how the practice supported families during times of bereavement and the action they took over and above what was expected of them.

Staff recognised patients emotional and social needs were as important as their physical needs. Staff provided us with examples and we saw evidence how patients were supported emotionally with their care and treatment. We heard how GPs had offered and had taken patients to hospital appointments when they required help and support emotionally with their care and treatment.

Good

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 clear systems and staff 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.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. The practice was part of a federation of other practices in the CCG. They met regularly and explored collectively how they could improve outcomes for patients. There was evidence the group was also engaging with other partners such as Harrogate District Foundation Trust to support this work.

Partners from health and social care in Harrogate and District have been chosen to take a national lead on transforming health and social care. Harrogate's Vanguard site is one of only 29 in the country to be chosen to lead the way in transforming care for local people. The aim will be to provide support to people to remain independent, safe and well at home with care provided by a team that the person knows and they can trust, set out in a universal care plan. This service will be provided by an integrated care team from community based hubs which include GPs, community nursing, adult social care, occupational therapy, physiotherapy, mental health and the voluntary sector. Dr Bannatyne & Partners had committed to be part of this.

The records showed the practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG) and patients and staff. The member of the PPG we spoke with told us the practice responded well to issues raised and recognised the importance of the role of the PPG in providing feedback.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services. The practice website allowed patients to change the language the website was displayed in and the check in system allowed patients to select an alternative language. Staff at the practice had completed training in equality and diversity training in the last 12 months.

The practice was situated on the first and second floors of the building. Patients could access the second floor via the stairs or lift. Waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. There was no emergency call system in the toilet. There was level access into the building and parking was available in the surrounding area.

Multi-disciplinary working arrangements were in place to identify patients whose circumstances may make them vulnerable. The information was shared regularly so that they were all aware of patients whose circumstances may have changed. For example, patients who may have become homeless.

The practice actively supported patients who had been on long-term sick leave to return to work by referring them to other services such as physiotherapists, counselling services and by providing 'fit notes' for a phased or adapted return to work.

Access to the service

The practice opened Monday to Friday 8:00 to 18:00. The practice offered extended opening hours on a Monday and Thursday from 18:00 to 20:00. The branch practice opened on a Monday 09:00 to 18:00 (closed from 12:30 to 13:30), Tuesday from 08:30 to 12:30, Wednesday from 09:00 to 13:00 and Thursday and Friday from 09:00 to 12:30. The dispensary at the branch surgery was open during these times. Appointments were available to patients to book in advance. Urgent appointments were released at 08:00 and 13:00 daily. Patients could be offered a triage telephone appointment or regular appointment with the duty GP or offered an appointment with one of the Advanced Nurse Practitioners. Patients could attend an appointment at either the main practice in Harrogate or the branch practice in Hampsthwaite.

The data we reviewed and the feedback from patients about the appointment system showed a generally high level of satisfaction. 95% said the last appointment they

Good

Are services responsive to people's needs?

(for example, to feedback?)

got was convenient compared to the CCG average of 93% and the national average of 92%. 90% of respondents said they were able to get an appointment to see or speak to someone the last time they tried, which was higher than the national average of 85% and the CCG average of 89%. The practice had increased the flexibility and length of time of their appointments to 12 minutes and 15 minutes for the duty doctor instead of 10 minutes to allow patients more time in their consultation. The practice reviewed their recall list each month and added on certain clinics if needed.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The national GP survey data was lower than the national and CCG average in respect of ease of access to the practice by phone and the experience of making an appointment. We saw evidence the practice had responded to this and had recently installed a new telephone system to mitigate the difficulties patients had experienced.

Home visits were made to four local care homes; all having a weekly dedicated surgery by their nominated GP. Ad hoc visits were also made when required.

Listening and learning from concerns and complaints

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

Information on how patients could make a complaint was available to patients in a number of areas; including the practice, the practice website and practice leaflet.

The practice had received thirteen complaints specific to the practice in the last twelve months. Records showed complaints had been dealt with in a timely way and were open and transparent. There was an active review of complaints and where appropriate improvements made as a result. Positive feedback from patients was also shared and celebrated among the staff.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had identified their vision which was promoted throughout the practice. For example, displayed on the practice noticeboard and referenced in the practice newsletter. They had adopted the vision of 'Safety, Quality and Friendliness'. All the staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these. Succession planning was evident in the records we looked at.

Governance arrangements

There was an effective governance framework, which focussed on delivering good quality care. The practice had a wide range of 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 at a sample of policies and procedures and all had been reviewed and were up to date.

There was a clear leadership structure with named members of staff in lead roles. This applied to all staff within the practice with all staff having clear roles which contributed to the effective running of the practice. The roles of staff within the practice were advertised for patients to see. For example there were photographs of staff and their roles displayed on notice boards and on the electronic screens. There was a high level of staff satisfaction. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes. Clinical and internal audit processes function well and have a positive impact in relation to quality governance, with clear evidence of action to resolve concerns.

Nursing staff were involved in a local peer review system with neighbouring GP practices. They looked at a range of areas. For example they had reviewed the use of new inhalers at the last meeting. We saw other examples where they had used peer review as an opportunity to measure its service against others and identify areas for improvement. There was evidence of a systematic approach to working with other organisations to improve care outcomes, tackle health inequalities and obtaining best value for money; being an active member of the Federation and the CCG to work towards achieving this.

There was an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. The practice recorded risks on individual risk assessments and action plans. Evidence showed these were kept under review and monitored for effectiveness. For example, ensuring that premises maintenance and safety was managed appropriately and monitoring the financial status of the practice. The practice held regularly meetings where performance and risk was discussed.

The practice had an identified member of staff who acted as the Caldicott Guardian and was clear about their role. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian; this was mandated for the NHS by Health Service Circular: HSC 1999/012.

Leadership, openness and transparency

Staff at all levels were encouraged to raise concerns. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. The practice had put in place a system called 'chatterbox' which was a tool to encourage staff to raise issues. We received other feedback from visiting professionals, patients and the PPG member that demonstrated the practices commitment to being open and transparent. The annual report and minutes of the PPG meeting were available for people to view on the practice website.

Staff had access to a range of policies and procedures to support them in their work. We reviewed a sample of these. For example disciplinary procedures, induction policy and management of sickness.

Seeking and acting on feedback from patients, public and staff

The practice gathered feedback in a variety of ways and demonstrated they analysed and acted on feedback. The practice obtained feedback via patient surveys, comment

Are services well-led?

Good

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

cards and complaints, friends and family test and via meetings. We looked at the results of the friends and family test and saw the practice analysed the findings and shared the results with patients in a number of ways. For example within the practice and in the quarterly newsletter. The newsletter highlighted what patients had said and what action the practice had taken.

The practice had a virtual patient participation group (PPG). The practice engaged with the PPG monthly to keep them updated of issues and to encourage feedback to current issues. We saw evidence of changes that had been introduced following feedback from the PPG. For example a number option for directing patients to the right place had been introduced for the telephone system. Records showed the practice had engaged with the PPG regarding the development of the PPG as this was identified as an area that needed development.

The practice gathered feedback from staff through staff meetings, peer meetings, engagement with the CCG, other practices, training and generally through appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff records and found that regular appraisals took place and staff had personal development plans. Staff told us the practice was supportive of training and they engaged in a wide variety of ways to learn and improve. For example, away days, meetings, peer support and attendance by visiting organisations and professionals, such as guest speakers and trainers. The practice was beginning to put measures in place to address the issue of not all staff having completed mandatory training.

The practice was a GP training practice. The feedback we received from a GP trainee was extremely positive regarding the quality of training they received.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. The practice had recently increased the frequency of reviewing significant events and incidents to further improve on the opportunity to learn and improve. The practice used the multi-disciplinary arrangements in place as a tool for learning and improvement. For example, the practice reviewed all deaths at these meetings.