# Scarborough Medical Group

## Quality Report

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

## Ratings

| | |
|---|---|
| Overall rating for this service | 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 Scarborough Medical Group on 6 November 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, safe, effective, caring and responsive services that met the needs of the population it served.

Our key findings were as follows:

- Patients who use the service were kept safe and protected from avoidable harm. The building was well maintained and clean.
- All the patients we spoke with were positive about the care and treatment they received. The CQC comment cards and results of patient surveys showed that patients were consistently pleased with the service they received.
- There was good collaborative working between the practice and other health and social care agencies that ensured patients received the best outcomes. Clinical decisions followed best practice guidelines.
- The practice met with the local Clinical Commissioning Group (CCG) to discuss service performance and improvement issues.
- There were good governance and risk management measures in place. The leadership team were visible and staff we spoke with said they found them very approachable.

We saw an area of outstanding practice:

- The practice undertook thorough investigations of significant events using a root cause analysis approach, this involved looking at system failures as well as individuals. This had resulted in the development of a service so patients on warfarin (a

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medicine that thins the blood) could have their blood test done at the practice which had resulted in the reduction of incidents related to patients taking the wrong dose of warfarin.

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

In addition the provider should:

- Ensure there is an audit trail of blank prescriptions forms.
- Ensure monitoring checks for health and safety and infection control are documented.

**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 widely to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. 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 above the local CCG average for nearly all indicators. Care and treatment was being considered in line with current guidelines and legislation. This included assessing capacity and promoting good health. Patient's needs were consistently met and referrals to other services were made in a timely manner. Staff worked with multidisciplinary teams. The practice undertook clinical audit and monitored the performance of staff. Staff had received training appropriate to their roles.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Feedback from patients about their care and treatment was very positive. Patients said they were treated with compassion, dignity and respect and they were 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. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and the practice responded to complaints and comments appropriately.

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**Are services well-led?**

Good

The practice is rated as good for being well-led. The leadership team was visible and it had a clear vision and purpose. 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. Governance arrangements were in place and there were systems for identifying and managing risks. Staff were committed to maintaining and improving standards of care. Key staff were identified as leads for different areas in the practice and they encouraged good working relationships amongst the practice staff. Staff were well supported by the GPs and practice manager.

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## 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. The practice was knowledgeable about the number and health needs of older patients using the service and actively reviewed the care and treatment needs of these patients. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. Patients over the age of 75 had a named GP. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

In conjunction with another surgery in the area the practice was recruiting two part time district nurses to facilitate the NHS England strategy "Avoiding Unplanned Admissions / Proactive Care Programme Enhanced Services". This was a strategy where the practice would liaise with local health and social care commissioners to work together for people with complex health needs. The nurses would work specifically with patients over the age of 75 to develop individualised care plans.

**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 nursing 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 named GP and a structured annual review to check that their health and medication needs were being met. There was a recall programme in place to make sure no patient missed 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

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A&E attendances. The practice offered comprehensive vaccination programmes which were managed effectively. Immunisation rates were relatively high for all standard childhood immunisations. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. Appointments were available outside of school hours and the premises were suitable for children and babies. All of the staff were responsive to parents' concerns and ensured children who were unwell could be seen quickly by the GP or nurse.

**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 this population group 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 provided a range of options for patients to consult with the GP and nurse, including on-line booking. Useful information was available in the practice and on the website 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. It had carried out annual health checks for people with a learning disability and 90% of these patients had received a follow-up. The practice offered these patients longer appointments. We found that all of the staff had a very good understanding of what services were available within their catchment area, such as supported living services, care homes and families with carer responsibilities.

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. They had access to the practices' policy and procedures and discussed vulnerable patients at the clinical meetings.

**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). The practice maintained a register of patients who experienced mental health problems including dementia. The register supported clinical staff to

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offer patients an annual appointment for a health check and a medicines review. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice offered access to other services, two days a week the Primary Care Mental Health Worker held clinics at the practice's surgeries. Information was available for patients on counselling services and support groups.

Staff had received training on how to care for people with mental health needs and dementia.

# Summary of findings

## What people who use the service say

As part of this inspection we had provided CQC comment cards for patients who attended the practice to complete. We received responses from 11 patients all of which were positive about the total experience they received from the practice. Patients said staff were polite and helpful and always treated them with compassion, dignity and respect. Five patients described the service as excellent. The nurses and GPs were praised for their compassion, professionalism and effective treatment.

We spoke with eight patients during the inspection and they also confirmed that they had received excellent care and attention and they felt that all the staff treated them with dignity and respect. Feedback from patients showed that staff involved them in the planning of their care and were good at listening and explaining things to them. They felt the doctors and nurses were knowledgeable about their treatment needs.

We looked at the results of the national GP survey for 2014 where 124 patients had responded. Results showed that patients were very positive about the service they received and the practice performed above the weighted CCG (regional) and national average in most areas. For example:

- 95% of respondents would recommend this surgery to someone new to the area - CCG local average: 88%
- 98% of patients said it was easy to get through to the practice on the phone - CCG local average: 86%
- 99% of respondents describe their overall experience of this surgery as good – CCG local average: 92**%**
- 92% of respondents said the last GP they saw or spoke to was good at giving them enough time – CCG local average: 92%
- 96% of respondents find receptionists at this surgery helpful – CCG average: 90%

We looked at the results of the Practice's survey for 2013/ 2014 which 100 patients had completed and saw they were also very positive about the services delivered.

These results were consistent with our findings on the day of the inspection.

We found that the practice valued the views of patients and saw that following feedback from surveys and from patients attending the practice; changes were made to improve the service.

## Areas for improvement

**Action the service SHOULD take to improve**

- Ensure there is an audit trail of blank prescriptions forms.
- Ensure monitoring checks for health and safety and infection control are documented.

## Outstanding practice

We saw an area of outstanding practice:

- The practice undertook thorough investigations of significant events using a root cause analysis approach, this involved looking at system failures as well as individuals. This had resulted in the development of a service so patients on warfarin (a medicine that thins the blood) could have their blood test done at the practice which had resulted in the reduction of incidents related to patients taking the wrong dose of warfarin.

# Scarborough Medical Group

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

a CQC Inspector and the team included a GP Specialist Advisor, a Practice Manager Specialist Advisor and a CQC Pharmacist Inspector.

## Background to Scarborough Medical Group

Scarborough Medical Group is situated in Scarborough and provides primary medical care services, which includes access to GPs, minor surgery, family planning, ante and post natal care to patients living in the Scarborough area. The practice provides services to 12555 patients of all ages. There is a higher percentage of the practice population in the 65 years and over age group than the CCG and England average and a lower percentage in the under 18 age group than the CCG and England average.

The practice has four GP partners and six salaried GPs, six male and four female. The practice is a teaching practice and has a GP registrar and a junior doctor working at the practice. The GPs and trainees provide 87.5 clinical sessions per week. There is one Senior Nurse/Nurse Manager, one nurse practitioner, four practice nurses, one treatment room nurse and two health care assistants. The nursing team provide 38.5 clinical sessions per week. There is one practice manager, one assistant practice manager and one data quality manager. The practice has a team of secretarial, reception, administrative and support staff.

The practice provided services to their patients through a General Medical Services contract.

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

The practice has opted out of providing out of hours services (OOHs) for their patients. When the practice is closed Prime Care provides OOHs services for patients. Information for patients requiring urgent medical attention out of hours is available in the waiting area and on the practice website.

The practice has two branch surgeries where regulated activities are also provided, South Cliff in Scarborough and Cloughton in Cloughton village. The Pharmacist Inspector visited Cloughton surgery to inspect the dispensary service and the lead CQC inspector and practice manager SPA visited the South Cliff Surgery to talk to the senior nurse and the secretary.

## Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out an announced inspection to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

# Detailed findings

## How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. We reviewed policies, procedures and other information the practice provided before and during the inspection. We carried out an announced visit on 6 November 2014.

During our visit we spoke with a range of staff including GPs, the GP registrar, senior clinical nurse, practice nurse and health care assistant. We also spoke with the practice manager, deputy practice manager, secretary, receptionists and dispensing staff. We spoke with eight patients who used the service and observed how staff spoke to, and interacted with patients when they were in the practice and on the telephone. We also reviewed 11 CQC comment cards where patients were able to share their views and experiences of the service.

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. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example staff had recently reported an incident where a medicine had continued to be prescribed after the patient had been advised to stop taking it.

We reviewed incident reports and minutes of meetings where incidents that had occurred over the past two years 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. There were records of significant events that had occurred during the last two years and we were able to review these. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held every six weeks to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. When reviewing incidents the practice considered that all mistakes are in part a system failure, and they always tried to improve the particular system identified. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the data quality manager. They showed us the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example the practice had identified that at their clinical incident meetings they were discussing three or four incidents each time concerning warfarin (a medicine which thins the blood) and incorrect doses been taken by patients. The practice decided that they would introduce a new procedure where the blood test would be done by the practice so the result was available while the patient was there and they could be told what dose of warfarin they needed straight away. The practice had purchased a machine for testing the blood and trained staff to use it. The GP told us that now they usually have no warfarin related incidents to discuss at the meetings. We saw minutes from a significant events meeting in September 2014 where incidents from the last 12 months were discussed and there had been no warfarin related incidents reported.

National patient safety alerts were disseminated by e mail to practice staff who then took any action required. 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 where necessary alerts were discussed at staff meetings to ensure all staff were aware of any action that needed to be considered.

**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 staff had received relevant role specific training on safeguarding children, however not all staff had received safeguarding adults training. 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 and document 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 appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary knowledge to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. The GP explained how they worked with the Health Visiting and Social Services teams when they had safeguarding concerns. For example they had liaised with social services when a patient had told them about something that happened to them when they were younger.

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 or patients with dementia. We saw that if a patient had dementia this was highlighted on their record.

GPs were appropriately using the required codes on their electronic records system to ensure risks to children and young people who were on looked after or child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health professionals such as health visitors, midwives and district nurses. We saw minutes of meetings where vulnerable patients were discussed.

There was a chaperone policy, and information informing patients that they could ask for a chaperone was visible in the waiting room 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). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

**Medicines management**

Arrangements for managing medicines were checked at the surgery and branch surgery. Medicines were dispensed for patients who did not live near a pharmacy. Staff told us that people who were eligible had the choice of having their medicines dispensed at the surgery or their local pharmacy. All prescriptions were reviewed and signed by a GP before they were given to the patient.

Staff showed us the standard operating procedures (these are written instructions about how to safely manage medicines) and we saw they covered all areas. We observed medicines being dispensed and saw arrangements were in place to minimise dispensing errors.

The practice had a safe system for reviewing hospital discharge and clinic letters. Where changes to medicines were recommended or made, these were highlighted promptly to GPs who made the necessary changes to patients' records.

Vaccines were administered by nurses and health care assistants using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of the directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

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. Expired and unwanted medicines were disposed of in line with waste regulations.

The process for the storage and recording of blank prescription forms had not been reviewed to ensure that there was an appropriate audit trail of blank prescription forms. Audit of this process would ensure that there was no diversion or misuse of blank prescription forms that could go undetected.

We saw a system was in place for managing national alerts about medicines such as safety issues. Records showed the alerts were distributed to dispensers, who implemented the required actions as necessary to protect people from harm.

Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. However, we observed some medicines were not safely stored. This was discussed with the Practice Manager on the day of our visit. We received an e mail from the practice manager the day after the inspection informing us of the actions they had taken to address this.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Good

# Are services safe?

We saw records showing all members of staff involved in the dispensing process had received appropriate training and had regular checks of their competence.

**Cleanliness and infection control**

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

Infection prevention and control (IPC) procedures had been developed which provided staff with guidance and information to assist them in minimising the risk of infection. There was a nominated lead for IPC who was responsible for ensuring good practice was followed. The IPC lead had completed training to assist them in undertaking the role and attended meetings with other IPC leads in the area. The practice monitored the standards of cleaning in the practice quarterly so any areas for improvement could be identified and actioned.

Staff told us there was always sufficient PPE available for them to use, including masks, disposable gloves and aprons and staff were able to describe how they would use these to comply with the practice's infection control procedures. For example staff told us they wore disposable gloves when handling specimens such as blood or urine. We saw that hand wash; disposable towels and hand gel dispensers were also readily available for staff. We observed that there was hand gel in the waiting area for patients to use. Staff confirmed they had completed training in infection prevention and control. Sharps bins were appropriately located, labelled, closed and stored after use. There was a contract in place for the removal of all household, clinical and sharps waste and we saw evidence that waste was removed by an approved contractor. Staff told us that equipment used for procedures such as cervical smear tests and for minor surgery were disposable. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We saw that other equipment used in the practice was clean.

Staff told us how they would respond to needle stick injuries and blood or body fluid spillages and this met with current guidance.

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 that a risk assessment had been completed which indicated there was no risk therefore the practice did not need to have regular legionella checks completed by an external company. The risk assessment was reviewed regularly in line with the practice policy.

**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 equipment maintenance logs and other records that confirmed this. The maintenance log identified the intervals that equipment or system checks needed be done, when they were last checked and when the next check was due. For example we saw that the electrical installation system had been checked in May 2011 and was due again in May 2016.

All portable electrical equipment was routinely tested and stickers were displayed on equipment indicating the last test date. We saw evidence of calibration of relevant equipment; for example we saw that the weighing scales and BP machines had been checked in November 2013 and they were due to be checked again the week after our inspection.

**Staffing and recruitment**

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The deputy practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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. Feedback from patients we spoke with and on the CQC comment cards and surveys confirmed they could get an appointment to see a GP or nurse when they needed to.

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 the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

**Monitoring safety and responding to risk**

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building and the environment. However these checks were not routinely documented. The practice also had a health and safety policy and health and safety information was displayed for staff to see. There was a member of staff who was trained as a risk assessor and they took the lead for responsibility for ensuring risk assessments were carried out and reviewed as required.

Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the findings from a recent fire brigade visit with staff and action had been taken to address their recommendations, one of which was to ensure fire extinguishers were mounted on the walls.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff told us about referrals they had made for patients with respiratory problems whose health had deteriorated suddenly and how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

**Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to manage emergencies. 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). Emergency medicines were available; these included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. We saw that anaphylaxis kits were available in each clinical room. Processes were in place to check the emergency equipment was working and that emergency medicines were within their expiry date and suitable for use. Records confirmed that equipment was checked regularly to ensure it was working and that medicines had not expired. All the medicines we checked were in date and fit for use.

Records showed that all staff had received training in basic life support and the staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. They all knew the location of the emergency airway equipment and medicines.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned staff sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. We saw a significant event analysis investigation had been carried out when a power cut had occurred. This showed how the practice had responded and confirmed that their business continuity plan had been implemented successfully.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

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 that guidance from local commissioners was readily accessible in all the clinical and consulting rooms. We discussed with the practice manager, GP and nurses how National Institute for Health and Care Excellence (NICE) guidance was received into the practice. They told us that this was downloaded from the website, disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

The staff we spoke with and the evidence we reviewed confirmed that 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 the nurse that staff completed thorough assessments of patients' needs in line with national and local guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The nurses told us they continually reviewed and discussed new best practice guidelines, for example for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

Staff described how they carried out comprehensive assessments which covered all health needs. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

National data showed that 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 patients, for example for patients with suspected cancers who were referred and seen within two weeks. We saw evidence that regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

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

**Management, monitoring and improving outcomes for people**

Staff from across the practice played a role in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling and medicines management. The information staff collected was then used by the practice to identify clinical audits required. The GPs told us clinical audits were often linked to medicines management information, NICE guidelines or as a result of information from the quality and outcomes framework (QOF).

The practice had a system in place for completing clinical audit cycles. The practice showed us three clinical audits that had been completed. 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 we saw that in May 2011 prescribing data showed the practice was a high prescriber

for one particular type of sleeping tablet that should only be for short term use. An audit was undertaken to review cases where it was been used to see if GPs were prescribing in line with current guidelines and the practice identified 229 patients that had been prescribed the medicine for a long time. A re-audit had been completed annually up to September 2014 which demonstrated that the prescribing rates for the medicine had reduced and only 10 patients were been prescribed the medicine, demonstrating it was now being used in line with current guidelines.

The practice also used the information collected for the quality and outcomes framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a 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). For example data for 2013/2014 showed 100% of patients with diabetes had received an influenza immunisation and 80.8% of patients diagnosed with dementia had received a face to face review in the previous 12 months. The data for 2013/2014 showed the practice was performing the same as or above the CCG and England average for all the clinical indicators including diabetes, asthma and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

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. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

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 had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also 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 rates for emergency admissions to hospital.

**Effective staffing**

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support and safeguarding children. There was a training matrix in place which outlined what training each member of staff required, when they had attended, or were due to attend and when any refresher training had taken place. This supported the practice in ensuring all staff attended required training.

We noted a good skill mix among the doctors, one had a special interest in dermatology, one in ophthalmology and cardiology, one had an interest in musculo-skeletal medicine and one in womens health. All GPs were up to date with their yearly continuing professional development requirements and had either 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

The nurses had also completed training in areas specific to their role, for example asthma, diabetes, cervical smears and immunisations. The staff we spoke with confirmed they had access to a range of training that would help them function in their role. The practice had protected learning time so staff were able to receive training on a regular basis. The GP told us they had five days per year for protected learning time and the nurses confirmed they had

protected learning time to update their knowledge in specialist areas, for example diabetes. Staff received appropriate professional development which meant they had the skills and knowledge to care for patients attending the practice.

There was an induction programme in place for new staff which covered generic issues such as fire safety and infection control. Staff told us that role specific induction, for example immunisation training for nurses would be available for new staff.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Staff told us the appraisal was an opportunity to discuss their performance, any training required and any concerns or issues they had. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example one of the nurses told us they doing the insulin initiation course in summer 2015. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

We saw there was a process in place to manage poor performance of staff members.

**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 requested the test or investigation was responsible for reviewing their own results and if they were on holiday the results were sent to the 'duty doctor' for that day. 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. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service to follow up patients discharged from hospital and had a process in place for this. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the system was working well, for example when the hospital discharge letter was received the nurse would contact the patient and arrange for them to be seen at the practice or for the nurse to see them at home.

There was a system in place to ensure the out of hour's service had access to up-to-date information about patients who were receiving palliative care which helped to ensure that care plans were followed, along with any advance decisions patients had asked to be recorded in their care plan.

The practice held multidisciplinary team meetings every month 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, palliative care nurses and decisions about care planning were documented in the patients' care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

**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 referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (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 called system one to coordinate, document and

Good

# Are services effective?

## (for example, treatment is effective)

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.

**Consent to care and treatment**

We found that 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 to understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability 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). 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 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 written consent was obtained and then documented in the electronic patient notes. We saw the consent form outlined the relevant risks, benefits and complications of the procedure and the clinician and patient both signed the form. Staff told us how they explained procedures to patients and checked their understanding before any procedure or treatment was carried out.

**Health promotion and prevention**

It was practice policy for all new patients registering with the practice to complete a health questionnaire to assess their past medical and social histories, care needs and assessment of risk, this was then reviewed. The GP was informed of all health concerns detected and these were followed up in a timely way. 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. Chlamydia testing kits were available in the patient toilets. 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 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 they were offered an annual physical health check. Between August 2013 and October 2014, 37 of 41 patients with a learning disability had received a health check. The practice had also identified the smoking status of 87.5% of patients over the age of 16 and actively signposted these patients to the community based smoking cessation clinics. QOF data for 2013/2014 showed that 98.2% of patients with conditions such as heart disease, stroke**,** hypertension, diabetes, respiratory problems , asthma, and mental health conditions who were recorded as current smokers had a record of an offer of support and treatment recorded in their records within the preceding 12 months. Performance for smoking cessation support for patients with these conditions was 5.5% above average for the local CCG area. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

Similar mechanisms of identifying 'at risk' groups were used, for example patients who were obese, those receiving end of life care and those who were carers. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 76.2%, which was in line with others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. The nurses were responsible for following up patients who did not attend for screening.

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 all immunisations was slightly below the CCG average for children aged 12 and 24 months and above the CCG average for children aged five. Again there was a clear policy for following up non-attenders by the practice.

Good

# Are services effective?

## (for example, treatment is effective)

There was a good range of health promotion information in the waiting room and on the practice web site. We saw that there were posters around the practice promoting services that may help support patients, such as smoking cessation and support with mental health.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey in 2014, a survey of 100 patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. For example 94% of respondents stated that the last GP they saw or spoke to was good at treating them with care and concern, the local CCG average was 91% and 96% said the GP was good at listening to them, the local CCG average was 93%. The satisfaction rates for the nurses for these two areas was 93% and 92% respectively for the practice and 93% and 94% for the local CCG average.

Patients were also very positive about their overall experience of the practice with 99% saying their overall experience of the surgery was good and 95% saying they would recommend the surgery to someone new to the area, the local CCG average was 92% and 88% respectively.

The practice had developed a new post of Patient Team Leader and a key part of their role was to monitor the quality of the service delivered by the reception team.

We received 11 completed CQC comment cards and spoke with eight patients during the inspection. All of the feedback was very positive about the service experienced. Patients said staff were polite and helpful and always treated them with compassion, dignity and respect. Five patients described the service as excellent. The nurses and GPs were praised for their compassion, professionalism and effective treatment.

Staff were familiar with the steps they needed to take to protect patient's dignity. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by partitions which helped keep patient information private. The practice had an open plan reception area and there was a notice requesting only one patient at a time to approach the reception desk. This assisted in patients not overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. There was a room available if patients wished to discuss a matter with the reception staff in private, and there was a notice informing patients that this was available.

We observed reception staff treating patients with respect and being extremely tactful when triaging requests. Data from the national patient survey 2014 showed 96% of respondents found the reception staff helpful, the local CCG average was 90%.

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 she would investigate these and any learning identified would be shared with staff.

**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 91% of practice respondents said the GP involved them in care decisions and 97% felt the GP was good at explaining treatment and results, the CCG area average was 86% and 90% respectively. The satisfaction rates for the nurses for these two areas was 91% and 93% respectively for the practice and 90% and 94% for the local CCG average.

Good

# Are services caring?

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. The practice website also had the facility for information to be translated into languages other than English.

**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. Feedback from the comment cards and the patients we spoke with on the day said they had received help to access support services to help them manage their treatment and care when it had been needed. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and the practice website also told people how to access a number of support groups and organisations. The practice's computer system alerted GPs and nurses if a patient was a carer. The nurses told us that they would signpost patients who were carers to support groups and services that could help them. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. The nurses told us they assessed patients with long term conditions for anxiety and depression.

Staff told us that if families had suffered bereavement their usual GP contacted them to express their sympathy and offer support. This 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 support services.

Information was available to signpost people to support services. This included MIND for help with mental health issues, the Macmillan service for support following bereavement and carers support groups.

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 systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example in conjunction with another surgery in the area the practice was recruiting two part time district nurses to facilitate the NHS England strategy "Avoiding Unplanned Admissions / Proactive Care Programme Enhanced Services". This was a strategy where the practice would liaise with local health and social care commissioners to work together for people with complex health needs. The nurses would work specifically with patients over the age of 75 to develop individualised care plans.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. One of the GPs was a board member for the local CCG and the practice manager was a member of the CCG Data Quality Group.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patients. For example patient feedback said that some patients had problems hearing the patient call system buzzer and the information was not displayed long enough. The practice had taken action and increased the volume of the buzzer and had extended the length of time patient names stayed on the screen.

**Tackling inequity and promoting equality**

The practice had recognised the needs of different groups in the planning of its services. For example they gave longer appointment times for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. All patients could be involved in decisions about their care.

The premises and services had been designed to meet the needs of people with disabilities. We found that the practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were accessible for patients with mobility difficulties and there was also access enabled toilets. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records. The practice manager told us how they responded to people who were visiting the area. Because of the location of the practice sites they told us that they got a lot of people who visited the area on holiday who would come into the practice requesting to be seen. They said they would treat people in the practice or support them until an ambulance arrived if it was more serious and they needed to go to hospital.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

**Access to the service**

Patients could make appointments in different ways, either by telephone, face to face or online, via the practice website. The Danes Dyke surgery was open from 8.00am to 6.30pm Monday to Friday, South Cliff from 08.00am to 6.00pm Monday to Friday and Cloughton was open 09.00am to 1.00pm Monday, Wednesday and Thursday and 2.00pm to 4.00pm Tuesday and Friday. Extended opening hours were available until 8.30pm on a Monday at Danes Dyke surgery. Patients could book an appointment at any of the surgeries so if Cloughton was closed they was could go to the other two surgeries. Patients who did not need an urgent appointment could book them in advance which freed up slots for patients who needed to be seen quickly. The GPs, nurses and receptionists all told us that if patients needed to be seen urgently they were given an appointment the same day.

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

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

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.

Patients we spoke with, feedback from CQC comment cards and the national patient survey confirmed that patients were able to get appointments when they needed them, this included same day appointments. We found that patients were very satisfied with the appointment system at the practice. Data from the national patient survey showed 95% of patients described their experience of making an appointment as good, the local CCG average was 83%. Reception staff told us they felt this system worked well and they felt they could always offer the patient an appointment.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were available for housebound patients and for those too ill to attend the surgery. Appointments were available outside of school hours for children and young people.

The practice also provided telephone consultation appointments. Patients who worked during the day or were unable to get to the practice had a choice of how they made their appointment and how and when they wanted to see the GP or nurse.

Patients could order repeat prescriptions via their local pharmacy, in person or by telephone. This meant the practice was using different methods to enable patients' choice and ensure accessibility for the different groups of patients the practice served.

The practice offered access to other services at their surgeries, for example at two of the surgeries the Primary Care Mental Health Worker and the Midwife worked one a day a week at each surgery.

**Listening and learning from concerns and complaints**

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Information on how to make a complaint was on the practice website, in the patient information leaflet and displayed in the waiting room. We saw that the complaints policy had details of who patients should contact and the timescales they would receive a response by.

Patients we spoke with told us they were not aware of the complaints procedure but if they were not happy with something they would raise it with a member of staff. None of the patients we spoke with had ever needed to make a complaint about the practice. Staff told us they were aware of the practice complaints policy and described how they would support someone who was not happy with the service. One of the nurses told us about a situation when a patient was not happy because the clinic was running behind and described how they had dealt with it and resolved it locally. Patients were now informed if a GP or nurse was running late.

The practice had received seven complaints since May 2014. These were dealt with in a timely way and had been investigated and satisfactorily handled. We saw that where relevant GPs, nurses and the practice manager had met with the complainant to discuss the issues raised and where possible the complaint had been resolved.

We saw that the practice had received a number of cards and letters thanking staff for their kindness, support and care.

# 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. We found details of the vision and practice values were part of the practice's strategy. These values were clearly displayed in the practice and on the website. The practice vision and values included providing high quality healthcare to the people of Scarborough and its surrounding district. The doctors, nurses and all other staff were dedicated to offering a professional service and helping keeping all patients up to date with news and information about the practice.

We spoke with ten members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

**Governance arrangements**

The practice had a number 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 11 of these policies and procedures and saw they had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding and governance. We spoke with ten members 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 if they had any concerns.

The practice used the Quality and Outcomes Framework (QOF) and data from the CCG to measure its performance. The QOF data for this practice showed it was performing above the local CCG and national average in nearly all the indicators. We saw that QOF and CCG data was regularly discussed at the team meetings and action agreed where necessary to maintain or improve outcomes.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. For example there were processes in place to frequently review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

We saw evidence that they used data from various sources, including incidents, complaints and audits to identify areas where improvements could be made. The practice regularly submitted governance and performance data to the CCG.

The practice had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example fire safety. The practice monitored risks on a monthly basis to identify any areas that needed addressing. However they did not document the findings.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example the practice was undertaking audits for the prescribing of sleeping tablets and painkillers. This ensured they were using these medicines in line with clinical guidelines and were using the most cost effective treatment available.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

**Leadership, openness and transparency**

We saw from minutes that practice meetings for all staff were held bi-monthly. All the staff told us that informal 'coffee time' meetings were held each day and these were used for staff to raise concerns and to share information and lessons learned from incidents. The senior partner was very clear about the practice's duty of candour and how important it was to learn from incidents. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days had been held. The practice had invited a Professor from the National Institute for Health and Care Excellence (NICE) to attend one of the away days to talk to the staff about prescribing. Staff we spoke with confirmed this and said they had found the day very useful.

The practice manager was responsible for human resource procedures. We saw that there was an induction procedure in place there were policies or procedures for disciplinary issues and bullying and harassment. We saw that

# Are services well-led?

Good

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

mechanisms were in place to support staff and promote their positive wellbeing. The staff we spoke with told us they were well supported, the practice was a lovely place to work and it was a lovely team.

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

The practice had gathered feedback from patients through the PPG, surveys and complaints received.

The practice had an established a Patient Participation Group (PPG) and a virtual group for patients that couldn't attend meetings. The PPG met every quarter. There was information on the practice website encouraging patients to become involved in the PPG and the virtual group. We spoke with three members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. They saw themselves as 'ambassadors' and said they played a key role as a link for the patients. One of the PPG members was also a member of the CCG PPG. They acted as a link and raised issues on behalf of patients to the CCG and fed back information from the CCG about services and performance at the practice PPG meetings.

We saw the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

There was a suggestion box on the reception desk in the surgery and patients could also provide feedback through the practice website. We found that the practice was very open to feedback from patients.

We did not see any evidence that staff surveys were undertaken but staff told us they could raise any issues at team meetings or with the GPs and practice manager.

The practice had gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training around insulin initiation and this had been arranged. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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 that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at appraisal records and saw they included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice was a GP training practice for GP Registrars, junior doctors and medical students

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. For example following discharge from hospital a patient had been self dosing a medicine without reference to the GP. The practice had amended its protocol for this medicine to ensure at first issue of a prescription the prescriber must ensure that the patient is being managed according to their protocol, and entered in the recall system.