# The Mayflower Medical Practice

## Quality Report

The Health Centre
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Bawtry
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Date of inspection visit: 15 January 2015
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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 inspection visit on 15 January 2015. The overall rating for the practice is good. Specifically, we found the practice was good in providing: safe, responsive and effective care for all of the population groups it serves.

Our key findings were as follows:

- Where incidents had been identified relating to safety, staff had been made aware of the outcome and action was taken where appropriate, to keep people safe.
- All areas of the practice were visibly clean and where issues had been identified relating to infection control, action had been taken.
- Patients received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to ensure they were up to date with best practice.
- The service ensured patients received accessible, individual care, whilst respecting their needs and wishes.
- We found there were positive working relationships between staff and other healthcare professionals involved in the delivery of service.
- Evidence we reviewed demonstrated patients were satisfied with how they were treated and this was with compassion, dignity and respect. It also demonstrated the clinicians were good at listening to patients and gave them enough time.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.
- Appointment length is need specific so GPs arrange longer appointments when they think this is necessary. Longer appointments are offered to some patients for example those with substance misuse issues or complex needs.
- The practice had systems to monitor babies and children; for instance there were always two members of the nursing team present when they administered the vaccinations. This was to minimise any errors that could occur due to the complexity of babies and children vaccinations

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for providing safe services. The practice building was clean and well maintained and systems were in place to oversee the safety of the building. Medicines were stored and managed safely. There were standard operating procedures and local procedures in place to ensure any risks to patient's health and wellbeing was minimised and managed appropriately. The practice learned from incidents and took action to prevent a recurrence.

It was evident good staffing levels were in place and there was an appropriate mix of skills within the team. We found staff recruitment was managed well with all the required checks in place. There were enough staff to keep people safe.

**Are services effective?**

Good

The practice is rated as good for providing effective services. Patients' needs were consistently met and referrals to secondary care were made in a timely manner. The practice worked collaboratively with other agencies to improve the service for patients. Patients' received care and treatment in line with recognised best practice guidelines. We saw patients' consent to treatment was consistently obtained.

The practice had carried out supervision and appraisals for staff. We saw staff had received training appropriate to their roles.

The clinical staff raised awareness of health promotion in consultations, the practice waiting areas and their web site. There were screening programmes in place to ensure patients were supported with their health needs in a timely and safe way.

**Are services caring?**

Good

The practice is rated as good for providing caring services. The majority of patients who responded to CQC comment cards, and those we spoke with during our inspection, were very positive about the service. They all confirmed staff were caring and compassionate and felt the practice provided a good service.

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

Good

The practice is rated as good for providing responsive services. The GP and staff understood the diverse needs of the different population groups they supported and made arrangements for these to be met.

# Summary of findings

Records showed staff responded appropriately and learned lessons when things do not go as well as expected or according to plan. There was a complaints policy available and staff knew the procedure to follow should someone want to complain.

**Are services well-led?**

Good

The practice is rated as good for being well-led. There was a long standing visible management team, with a clear leadership structure. Staff felt supported by the management team. There were good governance arrangements and systems in place to monitor quality and identify risk.

The practice was meeting patient's needs in providing a service where the GPs and nurses had specific lead responsibility for areas of care, for example safeguarding adults and children. Patients and staff felt valued and a proactive approach was taken to involve and seek feedback from patients and staff.

# 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 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 support. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice made provision to ensure care for older patients was safe, caring, responsive and effective. All patients over 75 years had a named GP. There were systems in place to ensure older patients had regular health checks, and their medication was reviewed and timely referrals were made to secondary (hospital) care. Health promotion programmes were available and information was available to carers.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medication needs were being met. The practice worked with relevant health and care professionals to deliver a multidisciplinary package of care. This helped to offer the patient a better overall experience in meeting their needs.

There were systems in place to ensure patients with multiple conditions received one annual recall appointment wherever possible. Healthcare professionals were skilled in specialist areas and their ongoing education meant this helped to ensure best practice was being followed.

The practice has special clinics for health needs such as, coronary heart disease, asthma and chronic obstructive pulmonary disease (COPD) and they had a system in place to identify patients who met the criteria to attend and also identified them quicker when they contacted the practice.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. The practice provided family planning clinics, childhood immunisations and maternity services. Staff ensured care for mothers, babies and young patients was safe, caring, responsive and effective.

# Summary of findings

Immunisation rates were relatively high for all standard childhood immunisations. We saw good examples of joint working with midwives and health visitors. There was health education information relating to these areas in the practice to keep patients informed.

**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 reviewed the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a range of health promotion and screening that reflects 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 with a learning disability and carried out annual health checks for this group. The practice also offered longer appointments for vulnerable patients.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. We saw evidence of practice staff advising and signposting vulnerable patients 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

We saw the practice monitored patients with poor mental health; they ensured patients had a regular physical health check and follow ups if there was non-attendance. The practice had access to professional support such as the local mental health team and psychiatrists.

The clinical staff offered annual reviews of their medicines, physical and mental health, and revision of their care plan.

# Summary of findings

## What people who use the service say

In the most recent information from Public Health England 2013/14 showed 80% of people would recommend this practice to others and 71% were happy with the opening hours.

We received four completed patient CQC comment cards and spoke with six patients on the day of our visit. Two of these comments on the comment cards were positive about the care provided by the GPs the nurses and reception staff with many comments conveying the excellent service they received by the practice overall. They all felt the doctors and nurses were competent and knowledgeable about their health needs. However one comment card mentioned they had problems with appointments and another mentioned a significant event they had reported to the practice.

The practice used to have a Patient Participation Group (PPG) which was very much in its infancy. It proved difficult to establish due to lack of interest and recruitment. The PPG is now non-existent. However in December 2014 the practice met with a representative from the CCG who assists practices with creating PPG's and it is their intention to form another PPG.

# The Mayflower Medical Practice

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC inspector and included a GP and a practice manager.

## Background to The Mayflower Medical Practice

The Mayflower Medical Practice is a dual sited, dispensing and training practice located in the centre of Bawtry. The building is an older building with good parking facilities and disabled access. The practice also has a purpose built satellite branch based in Finningley. This was also visited as part of this inspection. While Bawtry is in South Yorkshire it borders with North Nottinghamshire and North Lincolnshire. The practice has registered patients who live in different counties.

The practice is registered with the CQC to provide primary care services. The practice provides primary care services for 8200 patients under a General Medical Services (GMS) contract with NHS England in the Doncaster Clinical Commissioning Group (CCG) area. The GMS contract is a contract between a general practices and NHS England for delivering primary care services to local communities.

The practice has four GP partners (one male and four female), two advanced nurse practioners, four nurses (including the diabetic nurse who only sees the diabetic patients), one health care assistant and one phlebotomist working at the practices. They are supported by 13 administration and reception staff.

The practice is open at Bawtry from 8.00am to 6.30pm Monday to Friday. The opening times for Finningley are 8.00am to 12.30pm and 3.30pm to 6.00pm Monday, Tuesday, Thursday and Friday. On Wednesdays from 8.00am and close at 12.30pm. Due to having two sites patients can access appointments at either site and all staff work at both sites.

The practice treats patients of all ages and provides a range of medical services. When the practice is closed patients can access the out of hours provider service.

The practice population is roughly equally divided into 32% aged under 18 years of age, 36% aged between 18 and 65 years of age, with 32% aged 65 and over. Sixty two per cent of the patients have a long-standing health condition.

The CQC intelligent monitoring placed the practice in Band 4. 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. We identified the risks and discussed these with the GPs at the practice and these have been addressed as described in the report.

# Detailed findings

## Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This provider had previously been inspected before in November 2013 and were found to be compliant under the outcomes inspected.

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?

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew.

We carried out an announced visit on 15 January 2015. During our visit we spoke with a range of staff including the practice manager, two GP partners, one advanced nurse practioner and two reception staff. We also spoke with six patients on the day.

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We reviewed four CQC patient comment cards where patients had shared their views and experiences of the service. We also reviewed records relating to the management of the service.

Good

# Are services safe?

## Our findings

### Safe track record

Safety was monitored using information from a range of sources including the Quality and Outcomes Framework (QOF), patient survey results, patient feedback forms, the Patient Participation Group (PPG), clinical audit, appraisals, professional development planning, education and training. The practice had systems in place to monitor aspects of patient safety. Information from the (QOF), a national incentive and reward scheme that helps practices to focus better outcomes for patients, showed that in 2013-2014 the practice was appropriately identifying and reporting incidents. The practice had a rating of 96%. Information from the Clinical Commissioning Group (CCG) and NHS England indicated the practice had a good track record for maintaining patient safety. Staff we spoke with understood their responsibilities to raise significant events. This included the process to report them internally and externally where appropriate.

### Learning and improvement from safety incidents

We reviewed how the practice managed serious or significant incidents. Incidents were reported directly to the CCG. Records showed the system in place was managed in line with guidance issued by the National Patient Safety Agency. The practice had systems 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 12 months. We saw incidents were discussed at practice meetings. We talked with staff who confirmed any important information was passed onto them either via email or directly at team meetings.

Following a significant event at the hospital the practice developed a robust pertussis service to encourage pregnant mothers to have the pertussis vaccination. The practice offered the parents and family of this significant event support and counselling to help them through a very difficult period. A GP from the practice attended a multi-disciplinary meeting to discuss the events and a plan was developed to ensure that this type of incident did not occur again. The patients continue to have support from the practice.

We saw where patients had been affected by something that had gone wrong; the practice investigated the cause and in some instances reviewed their policies for example their registrar induction policy. When there had been any changes this was also included in other staff inductions and mentioned at staff meetings.

Staff told us they felt confident in raising issues with the GPs and felt action would be taken. It was clear there was a culture of openness operating throughout the practice, which encouraged errors and 'near misses' to be reported.

### Reliable safety systems and processes including safeguarding

The practice had systems in place to protect and safeguard children and vulnerable adults. The practice had a named lead GP for safeguarding. All GPs at the practice and staff had completed safeguarding training to support vulnerable patients. All staff we spoke with confirmed they had completed recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. This helped to ensure the protection of children and vulnerable adults.

We confirmed staff used appropriate codes on their electronic case management system for children and vulnerable adults. This helped ensure risks to these groups were known and reviewed. This system also alerted where a patient (child or adult) was vulnerable or required additional support, for instance if they were a carer. The practice also had protocols for babies and children; for instance there were always two members of the nursing team present when they administered the vaccinations. This was to minimise any errors that could occur due to the complexity of babies and children vaccinations.

There were chaperone notices displayed at the practice and a chaperone policy in place. There was evidence of patients being offered chaperone services during consultation and treatment and staff had appropriate guidance and training. Staff who provided this service which included reception staff had all been Disclosure and Barring service (DBS) checked this is to assure to the practice they were suitable to carry out this role.

### Medicines management

There was a policy for ensuring medicines were kept at the required temperatures, it described the action to take in the event of a potential failure. Staff confirmed the procedure to check the refrigerator temperature every day and how they ensured the vaccines were in date and stored

at the correct temperature. The staff showed us their daily records and we saw the correct temperature for storage was maintained. The cold chain for vaccines was audited and closely monitored by staff.

The practice is a dispensing practice at both locations. The amount of medicines stored was closely monitored and medicines were kept in a secure store with access by dispensing staff only. We checked medicines stored in the treatment rooms, medicine refrigerators and found they were stored securely and were only accessible to authorised staff. 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 dispensary team provided and issued medication storage devices designed to simplify the administration of solid oral dose medications to patients who may take many medications. This included those who were vulnerable or suffered from poor mental health; as well as patients who were diagnosed with dementia. The storage devices were made up at Finningley and then delivered by the practice driver to the patients at home.

The practice had commenced with repeat prescription on-line. However they were having some technical problems and were in the process of discussing these problems with the West and South Yorkshire business system support team. Patients could access the dedicated answer phone for ordering their repeat prescriptions. The practice also had red 'post boxes' in the waiting areas at both sites for patients to drop off their repeat prescriptions.

The dispensary had robust policies and protocols in place which comply with the Dispensing Services Quality Scheme (DSQS) which is a annual assessment for dispensing services. The dispensing team produced a Dispensary Information Leaflet which was at each dispensary and on their website. This leaflet gave hints and information to their dispensing patients.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. We saw this process was working.

We saw records of practice meetings that reviewed prescribing errors in the practice. There were systems in place to ensure GPs regularly monitored patients medication. The re-issuing of medication was closely monitored, with patients invited to book a 'medication review', when required. This was completed each month by the GPs who received a list of patients and then either updated the medicines or asked the patients to call into the practice. There was an annual review of medicines of patient's medication to ensure they were still appropriate and necessary. Any changes in medication guidance were communicated to clinical staff, and staff were able to describe an example of a recent medical alert and what action had been taken.

The nurses and health care assistant administered vaccines in line with legal requirements and national guidance. We talked with staff who confirmed they had received appropriate training to administer vaccines. The data from 2013-14 NHS England showed 98% of children aged 24 months at the practice had received their vaccinations.

**Cleanliness and infection control**

Patients we spoke with and responses from the CQC patient comment cards confirmed patients found the practice clean and had no concerns about cleanliness or infection control. We observed all areas of the practice to be clean, tidy and well maintained. The practice had an infection prevention and control (IPC) policy which had been reviewed in June 2014 and they had a designated lead for infection control. We saw there were cleaning schedules in place and cleaning records were kept for the practice. Suitable arrangements were in place to help ensure the practice was cleaned to a satisfactory standard.

We looked at the Infection Control Policy in place. An infection control checklist was used to help identify any shortfalls or areas of poor practice. Where concerns were identified, an action plan was put in place.

We confirmed infection control training had been completed by all the staff and refresher training was done on an annual basis.

An infection control audit had taken place in December 2014 and we saw evidence of this; any improvements identified for action were completed on time. There was an overall score of 90% for the Bawtry site while Finningley's overall score was 96%.The practice had a lead for infection control who had undertaken further training to enable

them to provide advice on the practice infection control policy. All staff received induction training about infection control specific to their role and received annual updates. At a recent independent audit areas were identified at the Bawtry practice who in turn have actioned this and contacted their landlord for the property.

We were told each member of staff was responsible for cleaning their clinical room and saw the nurses cleaning schedule. We saw the daily cleaning for their room had been recorded. The practice manager informed us they completed a monthly audit of the premises and if anything was not as it should be it was dealt with immediately.

The practice had access to spillage kits to enable staff to appropriately and effectively deal with any spillage of body fluids. Sharps bins were appropriately located and labelled.

The infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. They were able to describe how they would use these to comply with the practice's infection control policy.

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

The practice had a policy for the management at both sites for the testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records confirming the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

**Equipment**

The practice had equipment available to meet the needs of the practice for the management of emergencies. Emergency equipment included a defibrillator and oxygen which were readily available for use in a medical emergency. All the staff we spoke with knew the location of the equipment. We confirmed equipment was checked regularly to ensure it was in working condition.

We saw equipment had up to date annual Portable Appliance Tests (PAT) completed and systems were in place for routine servicing and calibration of equipment where required. The sample of portable electrical equipment we inspected had been tested and was in date.

**Staffing and recruitment**

The practice had a recruitment policy in place. The policy stated all staff should have a Disclosure and Barring Service (DBS) check and two references. We looked at a sample of personnel files for nurses, health care assistants and reception staff. Most of the staff had worked for the provider for several years. We looked at the most recently recruited staff and confirmed pre-employment checks were in place. Checks such as obtaining a full work history, evidence of identity, references and a DBS check, had been carried out prior to staff started work.

The provider routinely checked the professional registration status of GPs and practice nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) register each year to make sure they were still deemed fit to practice.

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**Learning and improvement from safety incidents**

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An infection control audit had taken place in December 2014 and we saw evidence of this; any improvements identified for action were completed on time. There was an overall score of 90% for the Bawtry site while Finningley's overall score was 96%.The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. All staff received induction training about infection control specific to their role and received annual updates. At a recent independent audit areas were identified at the Bawtry practice who in turn have actioned this and contacted their landlord for the property.

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**Equipment**

The practice had equipment available to meet the needs of the practice for the management of emergencies. Emergency equipment included a defibrillator and oxygen which were readily available for use in a medical emergency. All the staff we spoke with knew the location of the equipment. We confirmed equipment was checked regularly to ensure it was in working condition.

We saw equipment had up to date annual Portable Appliance Tests (PAT) completed and systems were in place for routine servicing and calibration of equipment where required. The sample of portable electrical equipment we inspected had been tested and was in date.

**Staffing and recruitment**

The practice had a recruitment policy in place. The policy stated all staff should have a Disclosure and Barring Service (DBS) check and two references. We looked at a sample of personnel files for nurses, health care assistants and reception staff. Most of the staff had worked for the provider for several years. We looked at the most recently recruited staff and confirmed pre-employment checks were in place. Checks such as obtaining a full work history, evidence of identity, references and a DBS check, had been carried out prior to staff started work.

The provider routinely checked the professional registration status of GPs and practice nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) register each year to make sure they were still deemed fit to practice.

We saw safe staffing levels had been determined by the provider and rotas showed these were maintained. Procedures were in place to manage planned absences, such as to cover training and annual leave, and unexpected absences such as staff sickness. We saw an audit report dated December 2014 and the action plan which covered these topics as it had been discovered there had been issues.

**Monitoring safety and responding to risk**

The practice management team looked at safety incidents and any concerns as they arose. They then looked at how this could have been managed better or avoided. They also reported to external bodies such as the Clinical Commissioning Groups (CCG), the local authority and NHS England in a timely manner.

The practice had arrangements for monitoring safety and responding to changes in risk to keep patients safe. For example, the practice had a health and safety policy setting out the steps to take to protect staff and patients from the risk of harm or accidents.

The practice was managing risk for patients. Patients with a significant change in their condition or new diagnosis were discussed at GP and multi-disciplinary team (MDT) meetings, which allowed clinicians to monitor treatment and adjust support according to risk.

Each lead had systems for keeping staff informed and ensured they used the latest guidance. For example, safety alerts were circulated via email to staff and relevant changes were made to procedures within the practice. The practice manager and staff also told us the alerts and events were discussed at relevant staff meetings where the information was reinforced. Staff who we spoke with told us that reflection and learning was a regular occurrence.

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

We saw evidence all staff had received training in Basic Life Support. This was updated on a regular basis. There was oxygen, emergency drugs and a defibrillator in both practices. All staff knew where these were kept and how they should be used. Emergency medicines were available, such as for the treatment of cardiac arrest and anaphylaxis, and all staff knew their location. Processes were in place to check emergency medicines were within their expiry date.

We spoke with staff who told us what they would do in the event of an emergency for example a sudden illness or if

Good

# Are services safe?

the premises had to be evacuated. We saw emergency medicines and equipment were accessible to staff and systems were in place to alert GPs and nurses in the event of an emergency.

We saw there were business continuity plans in place to deal with emergencies that may interrupt the smooth running of the service such as power cuts and adverse weather conditions. The plans were accessible to all staff. This provided information about contingency arrangements, staff would follow in the event of a foreseeable emergency. A recent example was a heavy snowfall and the arrangement they had with a local farmer to clear access to the Finningley location.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF). The QOF aimed to improve positive outcomes for a range of conditions such as coronary heart disease and high blood pressure. The practice achieved 95 per cent of the QOF framework points in 2013-14, which showed their commitment to providing good quality of care. From information we had at our disposal we spoke with the GP about the number of Ibuprofen and Naproxen prescribed as a percentage of all non-steroidal anti-inflammatory drugs items prescribed from (01.01.13 to 31.03.14). The practice has previously audited this in the past and they feel whilst they over prescribed, they felt this was partly due to patients preferring to buy over the counter medications.

All GPs and nurses demonstrated how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. For instance, they applied the NICE quality standards and best practice guidance in their management of conditions such as asthma and diabetes. We saw minutes of GP clinical meetings where new guidelines were disseminated and the implications for the practice's performance and patients were discussed. The GPs interviewed were aware of their professional responsibilities to maintain their knowledge.

The practice also held multiple clinics and services to meet the needs of the practice population; these included those patients with long-term conditions such as coronary heart disease (CHD) and chronic obstructive pulmonary disease (COPD). Other clinics included: hypertension, medication reviews, childhood immunisation and well-baby clinics, antenatal and post natal clinics and general health checks. They also offered clinics or services for, asthma, family planning, wound care, minor surgery, patients over 75, seasonal vaccines, travel advice and immunisations, weight loss, drug, alcohol and smoking cessation. They also offered an un-funded phlebotomy service to the patients, although sometimes the patients were asked to attend the local hospital in Doncaster. We were shown examples of patients long-term conditions management plans which they used to avoid unplanned admissions to secondary services.

The practice has a community midwife attached to the practice, who sees pregnant mothers at both sites. The Practice had also developed a new system for 'new mums' to ensure they register the baby quickly. This enabled the baby and mother be seen at the six to eight week check and established when the baby vaccinations were to commence. The practice identified some disparity between how the midwives in Nottinghamshire and South Yorkshire worked so they have adapted a system that works for their 'new mums'.

The practice hosts an on-site Improved Access for Psychological Therapies Service (IAPTS) for patients who required further help in relation to their mental health, social health, physical health and any safeguarding issues. They also have counsellors who attended the practice on a weekly basis to see patients that had been referred to them.

The practice had registers for patients needing palliative care, learning difficulties, mental health issues, diabetes, asthma, and COPD. This helped to ensure each person was monitored and supported with their care, which was regularly reviewed. Additionally regular palliative care meetings were held and they included other professionals involved in the individual patient's care.

We saw patients were appropriately referred to secondary and community care services. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring each patient was given support to achieve the best health outcome for them. Feedback from patients confirmed they were referred to other services or hospital when required

All GPs we spoke with used national standards for referral, for instance two week referrals for patients with suspected cancer were completed there and then, and other routine appointments via 'choose and book' were also confirmed the same day. Although we did notice not all the GPs preferred to use this system. The practice in tandem with 'choose and book' also used the Lexacom system which was run from the Finningley site and secretaries were aware of which GPs used which system.

There were systems in place to identify and monitor the health of vulnerable groups of patients. Specific coding was used for patients on their electronic records. This coding

Good

# Are services effective?

## (for example, treatment is effective)

records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. They improve patient care by ensuring clinicians based their judgements on the best possible information available at a given time. The GPs and nurses we spoke with were all familiar with read coding and its benefits when assessing patients' conditions.

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

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and a long term audit of those on the long term use of metoclopramide prescriptions. The practice was making use of clinical audit tools to reflect on the outcomes being achieved and areas where they could be improved. The GP we spoke with informed us clinical audits were often linked to medicine management information and safety alerts. We found there were mechanisms in place to monitor the performance of the practice and the clinician's adherence with best practice to improve outcomes for people. Additional medicines reviews were carried out for patients where it was felt a change in prescribing guidelines would affect their medication.

We saw the practice had a system in place for monitoring and reviewing patients with long term conditions this included chronic disease. The practice was taking part in the Avoiding Unplanned Admissions (AUA) they identified 147 patients on the AUA list which was managed by the practice manager. These patients were identified using a Risk Assessment Tool (RAT), provided by the CCG. The patients on the register had been allocated a named GP and in some cases a care co-ordinator. As well as using RAT the Practice had also identified other patients, including younger ones, who they felt may benefit from this service. This register also included some nursing home patients. This list was monitored and updated regularly.

The practice had also signed up to the local CCG initiative which was funded for two years called Transforming Primary Care (TPC). This was generally for their older patients.

The AUA and TPC are similar services. However the TPC is for practices (in the same constituency) to work alongside each other developing appropriate proactive case management plans for their most vulnerable patients. Ultimately to develop comprehensive care management programmes. The Practice team (clinical and non clinical) identified patients they felt may need more support to help them manage their current health or social issues. As a result of this the practice recruited a minor illness nurse to be the care co-ordinator for this role. The minor illness nurse explained the service to the patients when she saw them in practice or visited them in their home.

Additionally the clinicians monitored their performance against the local Quality and Outcomes Framework (QOF) targets. We saw evidence that audits, learning, updates and action taken were monitored and shared at their clinical meetings. Although they did state they were moving away from the QOF reviews and going towards a care planning/ holistic approach. This included long term condition reviews and they felt care was more individualised.

The practice had a list of housebound patients who were visited on a regular basis. This included patients who were vulnerable in any form for example medically or socially could be visited by healthcare professionals.

Staff regularly checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked patients receiving repeat prescriptions had been reviewed by the GP. The GPs from the practice met regularly with the CCG and other practices. These meetings shared information, good practice and national developments and guidelines for implementation and consideration.

**Effective staffing**

All the patients we spoke with were complimentary about the staff. We observed staff were competent and knowledgeable about the roles they undertook. The practice was organised so there were enough staff to meet the fluctuating needs of patients.

We saw checks were made on qualifications and professional registration as part of the recruitment process and additional checks throughout the clinician's appointment. There was a comprehensive induction programme in place for new staff which covered generic issues such as fire safety and infection control.

Good

# Are services effective?

## (for example, treatment is effective)

We saw evidence staff had completed mandatory training, for example basic life support, safeguarding and infection control. Staff had been trained in areas specific to their role for example, wound management, heart disease, diabetes and COPD.

We saw evidence of regular protected learning time. 'Target' training was offered externally to GPs, whilst 'in house' training was provided to other staff on the same date. We saw the practice kept an accurate account of training completed or training requiring an update.

All GPs were up to date with their continuing professional development requirements. The nurses in the practice were registered with the Nursing and Midwifery Council (NMC). To maintain registration they had to complete regular training and update their skills. The nurse we spoke with confirmed their professional development was up to date.

The clinical and non-clinical staff confirmed they had annual appraisals. They told us it was an opportunity to discuss their performance and any training concerns or issues they had. All the staff we spoke with felt they were well supported in their role and confident in raising any issues with the practice manager or the GPs.

There were Human Resources (HR) policies and procedures in place to support poor or variable performance amongst staff. We saw where performance concerns had been identified appropriate action had been taken to manage this. The practice had created a staff incident logbook; this was for mistakes they may have made. Any member of staff could insert an entry into the logbook. This was then followed up almost immediately and any issues could be dealt with there and then. Although if there became a pattern the matters could be escalated to their disciplinary system.

### Working with colleagues and other services

The practice worked with other service providers to meet patients' needs. Treatment information from hospitals and Out of Hours Service (OOHs) which is provided by a private company Danum Medical Services Ltd (DMSL) was received and reviewed as per the practice policy. 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 worked well.

We saw evidence the practice worked closely with other professionals. For example they worked with palliative care nurses, health visitors, social services, community learning disability teams and community mental health teams to support patients. The GP explained the staff now attended multidisciplinary team meetings every two months 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, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of these meetings as a means of sharing important information.

### Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner.

The staff told us they liaised closely with the health and social care providers to ensure any health needs of their patients were promptly addressed, for example when someone was discharged from hospital. The GP would review patients who were deemed at risk on discharge from hospital. The GP reads the discharge letters and flags up the need for a review. This was important to ensure integrated care and support was provided to the patients.

There was a practice website with information for patients including signposting services available and the latest news. Information leaflets and posters about local services were available in the waiting area.

### Consent to care and treatment

We found the healthcare professionals understood the purpose of the Mental Capacity Act (2005) and the Children Act (1989) and (2004) and were able to describe how they implemented it in their practice.

They confirmed their understanding of capacity assessments and how these were an integral part of clinical practice. They also spoke with confidence about Gillick competency assessments of children and young people. This checks whether these patients had the maturity (at age 16yrs or younger) to make decisions about their treatment. Clinical staff we spoke with understood the principles of gaining consent including issues relating to capacity.

Good

# Are services effective?

## (for example, treatment is effective)

All the staff we spoke with were aware of when written consent should be obtained and when informed consent could be given verbally. The staff knew when they should update the patients' notes when verbal consent had been provided. Staff told us they spent time discussing treatment options and plans with patients and were aware of consent procedures. They explained discussions were held with patients to assure their consent prior to treatment. They were aware of how to access advocacy services. Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing.

There was a practice policy on consent in place. Staff were able to provide examples of how they dealt with a situation if someone was unable to give consent, including escalating this for further advice to a senior member of staff where necessary. We found clinical staff understood how to facilitate 'best interest' decisions for people who lacked capacity and would seek appropriate approval for treatments.

**Health promotion and prevention**

The practice raised patients' awareness of health promotion. This was in consultations, links on their web site and leaflets in the practice. This information covered a variety of health topics including diabetes, smoking cessation, weight management, stroke and diabetes. Patients confirmed with us they had access to the information and staff regularly discussed health promotion with them during their consultations and on home visits.

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 above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

The practice nurses were responsible for the recall, monitoring and health education for people with long term conditions (LTC) and these included conditions such as diabetes and COPD. The clinical staff had a clear understanding of the number and prevalence of conditions being managed by the practice. They told us how they recalled patients with these conditions, usually annually or more regularly if required. They ensured no one missed being sent a follow up review.

The practice offered NHS Health Checks. Patients were invited for their health checks annually based on their birth date. Medicine reviews and long-term conditions were reviewed at the same appointment to avoid multiple visits for the patient. The practice had lists of patients who needed additional support. For example, the practice kept a register of all patients with a learning disability, chronic disease or mental health problem and these patients were offered an annual physical health check.

The practice website provided access to patient information and links to other websites such as NHS Patient Information websites. A range of health information leaflets were also displayed in the practice waiting area.

The patients we spoke with were very complimentary about the level of information they received about their treatments and possible side effects of medicines during consultations.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We observed reception staff were courteous and spoke respectfully to patients. They listened to patients and responded appropriately. The practice switchboard was located in an area away from the reception so calls could not be overheard. The staff we spoke with told us they were always careful about what questions they asked patients at the reception desk and they were aware of the need to maintain confidentiality. In the NHS England survey 2013-14 patients were asked if maintained their confidentiality in the reception area. The practice performed as well as most other practices. We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private.

Staff and patients told us consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting and treatment rooms so that patient's privacy and dignity was maintained during examinations, investigations and treatments. We noted doors were closed during consultations and conversations taking place in these rooms could not be overheard. The staff were aware of the practice policy on chaperoning and were familiar with arrangements to maintain the dignity and privacy of patients undergoing intimate examinations.

Patients' on-going emotional needs were supported. Leaflets were available in the waiting room which offered support to patients for areas such as; bereavement counselling, mental health support and also support with conditions such as cancer. Staff also confirmed that GPs always contacted patients after a bereavement in their family to offer condolences and further support. We saw evidence of this through an on-going significant event.

We received four completed CQC patient comment cards where patients shared their views and experiences of the service. We also spoke with six patients on the day of our inspection. We spoke with people from different age groups, who had varying levels of contact and varying lengths of time registered with the practice. Generally patients were happy with the care they received although there were negative comments about accessing appointments and the triaging service.

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

Patients we spoke with on the day of our inspection told us 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. Of the patients who participated in the national GP patient survey in 2013-14, 85% of respondents said the GP they visited was 'good' at treating them with care and concern. 78% said they were involved in decisions about their care. These were in line with national averages. They also expressed their GP had satisfactorily explained their condition and the treatment they needed. Patients we spoke with said they had been involved in decisions about their care and treatment, and staff explained things clearly to them.

We found the older patients with health needs had care plans and patient involvement in agreeing these. They had received where appropriate information and support about end of life planning.

Patients with long-term conditions had patient held records which highlighted agreed personal objectives and had appropriate health promoting advice to follow between appointments with their clinician.

Staff told us that translation services were available for patients who did not have English as a first language. Although, this was not needed regularly because the majority of the patient population did have English as their first language.

We spoke with the GP about the proportion of respondents to the GP patient survey who stated they always or almost always see or speak to the GP they prefer. The practice was aware of this but felt due to being dual sited and a training practice this did not impact on the ability to see the GP of patient choice. They had appointments on the day as well as the triage service and a variety of other appointments. Two of the partners were less than full time which impacted on the availability of GP of patient choice.

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

Good

# Are services caring?

The patients we spoke to on the day of our inspection told us staff were caring and understanding when they needed help and provided support where required.

Notices in the patient waiting room and patient website also signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. There was written information available for carers to ensure they understood the support available

We found because of the locations of the practices, older patients were routinely offered home visits. The practice recognised their isolation by being in a rural location as a risk factor and endeavoured to support these patients in a holistic caring way. We were told by the nursing team how pro-active clinicians were with patients who had multiple long term conditions.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The practice provided a service for all age groups. Every patient no matter their age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation would receive care.

We found GPs and other staff had the overall competence to assess each patient and were familiar with individual's needs and the impact of their socio-economic environment.

Longer appointments were made available for people who needed them and those with long term conditions. This included appointments with a named GP or nurse. There was a register of the housebound and patients who required palliative care.

We saw there was a process in place for referrals to other services. We saw referrals the practice had made to other services.

The practice had a GP led triage appointment service. This enabled patients who had an urgent need to either speak or see a healthcare professional on the day. When a patient contacted the practice the reception team completed a Triage Slip ensuring they had the presenting problems. If a patient mentioned a specific word the reception team would instruct the patient to ring 999. These words were on the triage protocol which was fixed to each reception computer desk.

The triage slips were then placed in the triage box for the duty doctor to evaluate them and contact the patient. Once the duty doctor had contacted the patient the appointment was either offered by the duty doctor or the receptionists were asked to contact the patient. Every patient was asked to keep their phone lines available and if they had no contact from the practice by 11:00 am then they were requested to call the practice back. If the practice received an urgent request to see a GP that does not fit the emergency 999 protocol then the receptionists took this urgent triage to the duty doctor immediately. This allowed a quicker response/plan to be put in place.

We looked at how the practice met the needs of older people. We saw the practice had a named GP for over 75s and provided patients with an 'elderly health check' to support them with management of any long term conditions. This included a system that recalled patients annually for a comprehensive review. The practice each month made a search of their patient list to ensure they captured the patients who had turned 75 and wrote to them to inform them of this service and of the name of their named GP.

Staff understood the lifestyle risk factors that affect some groups of patients within the practice population. We saw the practice provided a range of services and clinics where the aim was to help particular groups of patients to improve their health. For example, the practice provided patients with access to smoking cessation programmes, and advice on weight and diet.

**Tackling inequity and promoting equality**

There was ramp access to the building and accessible toilets. Disabled parking bays were available. There was a waiting area on the ground floor at both sites. We saw the ground floor waiting area was large enough to accommodate patients who used 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.

Staff told us translation services during consultations were available for patients who did not have English as a first language.

The practice had recognised the needs of different groups in the planning of its services. For example, the practice had systems in place which alerted staff to patients with specific needs who may require a longer appointment or additional assistance while attending the practice.

**Access to the service**

Of the patients who participated in the national GP patient survey in 2013-14, 76 % of patients reported generally, how easy it was to get through to someone at their GP surgery on the phone. A further 71% were either very satisfied or fairly satisfied with their GP practice opening hours. However one comment card mentioned they had problems with appointments. These percentages were in line with national averages.

The practice offered telephone and on line pre bookable appointments. Patients could also ring on the day for emergency appointments. Patients we spoke with told us they always got an appointment the same day if it was an

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

emergency. All children were usually seen the same day when contacting the practice. Older patients were also seen the same day and home visits were available when required for housebound patients. Patients confirmed the practice was accessible and they never waited long to gain a routine appointment.

We saw good systems were in place to help patients order repeat prescriptions. Patients used the web site, telephone or visited the surgery to order prescriptions.

Opening times and closures were stated on the practice website and in the practice leaflet with an explanation of what services were available. The practice also produced a practice newsletter which gave vital seasonal information.

**Older People**

The practice provide for older people with a named GP for all patients over the age of 75. They undertook the Avoiding Unplanned Admissions, they had used the Risk Stratification Toolkit to find suitable patients for this service. They also included patients who they felt would benefit from this service and who were not identified with the toolkit. The practice also offered a service called Transforming Primary Care (TPC) which is similar to the Avoiding Unplanned Admissions. This was a nurse led service and was for patients who were "struggling" with short term, noncomplex health issues. The patients for this list were generated by the whole practice teams, putting forward patients names they felt would benefit from this nurse led service.

**People with long-term conditions**

The practice provided a robust call and recall system for patients with chronic long term conditions. They had qualified nurses in asthma, COPD, CKD, Hypertension, CHD, Spirometry, and diabetes who were able to give patient with these long term conditions care and a timely recall service.

**Families, children and young people**

The practice provided childhood vaccinations and baby immunisations. They worked in conjunction with the community midwife to ensure their pregnant mothers received the Pertussis information and vaccination at the right time during their pregnancy. They also had a "New Mum" service where they contacted the new mother after they had received the mother and baby discharge notification from the hospital. They then booked the mother and baby an appointment. If any family contacted the practice with a poorly child who needed to be seen the practice had the ability to offer an appointment for the child on the same day. They provided a family planning services which included the fitting of coils and Implanon.

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

The practice provided a successful triage appointment system. This system allowed working age people to contact the practice and to be able to speak with a GP on the day. This then allowed the GP to either deal with their health issue over the phone or offered them an appointment later on in the day or an early appointment the following day. They also had the ability for patients to book appointments up to 4 weeks ahead.

Students who had come back home from university during holiday periods could register with the practice on a temporary basis. They also offered the Meningitis C vaccination for students who were starting University.

**People whose circumstances may make them vulnerable**

The practice provided patients who were experiencing a difficult time in their life with support via the Transforming Primary Care service. The ability to access the triage appointment service seeking advice and support quickly from the practice.

The practice had a palliative care register which enabled them to ensure the patients and their carers received extra care/input when it was needed the most.

The practice held monthly Child Information Form (CIF) meetings with the Health Visitors and GP and discussed any concerns relating to children for example safeguarding and care concerns.

The practice had signed up to the Learning Disability Direct Enhanced Service (DES). They have a trained GP and the nurse responsible for this DES has received Learning Disability training to assist the GP. The practice were the registered doctors for two local homes for patients with learning disabilities.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

The practice had signed up to the Alcohol DES and contacted the patient with advice about safe drinking. These patients could be put forward by the whole team to the dedicated nurse to allow a named contact and further care from the practice.

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

The practice provided support to patients experiencing poor mental health by offering annual reviews and care plans along with physical health assessments. They had the benefit of Improving Access to Psychological Therapies (IAPT) and counsellors on site to help these patients. They had signed up to the Dementia Friendly Training and carried out dementia screening on their patient population.

**Listening and learning from concerns and complaints**

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

We were also informed by the practice manager and staff, that all complaints or information of concern were discussed at the GP/clinical meeting and shared at their practice meetings. This included the action taken and any learning for the practice.

We saw information was available to help patients understand the complaints system. Information on how to make a complaint was available and displayed in the reception area. There was a suggestion box in the waiting area for patients use. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. The practice manager kept a log of complaints about the practice. We looked at the 13 complaints over the past 12 months. We saw these complaints were investigated and concluded in accordance with the practice's guidelines and procedures. The complaints, investigations and the findings showed openness and transparency. We also saw patients were responded to in a timely and respectful way, and as a result of the complaints we saw how the practice implemented any changes identified.. The practice encouraged complaints/comments and they placed a review of these on their website.

# 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**

Staff we spoke with shared joint values about the practice and knew what their responsibilities were in relation to these. All staff spoke positively about the leadership and they felt valued as employees at the practice. They said this was central to the practice in all their decision making, planning and development.

There was an established management structure within the practice. The practice manager, GPs and staff were clear about their roles and responsibilities and the vision of the practice. They worked closely with the local CCG and were committed to the delivery of a high standard of service and patient care. We spoke with the GPs who demonstrated an understanding of their areas of responsibility and their role ensured they delivered a quality service every day.

Patients were encouraged to be involved in decision making. We saw there was input from key stakeholders, patients and staff which ensured the practice regularly reviewed their aims to ensure they were being met. The practice leaflet and website showed how the practice was interested in the views of patients. We saw how the practice worked with these views so they could use them to improve the service. Staff told us central to their values was the needs of the patient. We saw from the minutes of meetings, including the practice training days patients and staff were involved in developing and achieving the vision of the practice.

Monitoring took place, and this included audits that ensured the practice was achieving targets and delivering safe, effective, caring, responsive and well led care of a high standard at all times.

**Governance arrangements**

The practice had effective management systems in place. The practice had policies and procedures to govern activity and these were accessible to staff. We saw the policies incorporated national guidance and legislation, were in date; reviewed and updated. We found clinical staff had defined lead roles within the practice. For example, the management of long term conditions, medication prescribing, safeguarding children and adults. Records showed and staff confirmed they had up to date training in their defined lead role.

The practice held meetings where governance, quality and risk were discussed and monitored. The practice used the Quality and Outcomes Framework (QOF) to measure their performance. We were told the clinical team regularly discussed QOF data at their meetings and where appropriate action plans were agreed monitored and reviewed.

We found effective monitoring took place. The practice had systems in place for completing clinical audit cycles to ensure the practice achieved targets and delivered safe, effective, caring, responsive and well led care.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager produced arisk log, which addressed a wide range of potential issues. We saw the risk log was regularly discussed at clinical meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

The practice sought feedback from patients and staff to help improve the service. All the staff we spoke with felt they had a voice and the practice was supportive and created a positive learning environment. They all told us they felt valued, supported and knew who to go to in the practice with any concerns.

**Leadership, openness and transparency**

The practice was committed to on-going education, learning and individual and team development of staff. The performance of staff was the subject of monitoring and appraisal at all levels; which reflected the organisational objectives. There were lead roles within the team for different aspects of the service. For example, infection control and vaccinations/ immunisation programme.

We saw the practice's training matrix for staff. The practice was able to identify what training each person had received, the dates they attended, when it was due to expire and when any refresher training was due.

There was good communication between staff. The practice had a proactive approach to incident reporting. They discussed if anything however minor could have been done differently at the practice.

Staff we spoke with told us all members of the management team were approachable, supportive and appreciative of their work. They were encouraged to share

# Are services well-led?

Good

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

new ideas about how to improve the services they provided. Staff also spoke positively about the practice and how they worked collaboratively with colleagues and health care professionals.

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

The practice had gathered feedback from staff, through staff training days, staff appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff confirmed they felt part of the decision making in the practice and their contribution mattered to the team. Staff told us they attended staff meetings and had the opportunity to discuss the service being delivered, feedback from patients and to raise any concerns they had. They also told us how they felt valued and supported in their work and the culture was one of openness and transparency.

We reviewed the most recent data available for the practice on patient satisfaction from their comments and complaints review. The evidence from this demonstrated that patients were generally satisfied with the care and treatment provided by the practice and how they were treated. This included the testimonials on the website.

Patients we spoke with felt the staff listened to their views and welcomed feedback to inform how the practice could best meet the needs of their patient groups.

**Management lead through learning and improvement**

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. The practice was also a training practice for medical students.

We looked at four staff files and saw regular appraisals had taken place which included a personal development plans. Staff told us the practice was very supportive of training and they were given protected time to undertake further training.

The practice had completed reviews of significant events and other incidents and shared the findings with staff at meetings and training afternoons to ensure the practice improved outcomes for patients.