Tadcaster Medical Centre

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an inspection of Tadcaster Medical Centre on 2 June 2015, as part of our comprehensive programme of inspection of primary medical services. The inspection team found after analysing all of the evidence that the practice was safe, effective, caring, responsive and well led. It was rated as good for all of the population groups.

Our key findings were as follow:

- The practice is safe. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- The practice is effective. 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. According to the data from Quality and Outcomes Framework (QOF), an annual reward and incentive programme showing GP practice achievement results, outcomes for patients registered with this practice were above average.
- The practice is caring. Patients reported the positive view they had of the doctors and staff at the surgery. Practice staff knew their patients well. We received many examples of how their GPs acted 'over and above' their expectations from them; these included contacting patients over the weekend and home visiting after accidental deaths. The practice ensured patients received accessible, individual care, whilst respecting their needs and wishes. The QOF indicators showed that patients felt listened to and involved in decisions about their care and this was similar to other practices in the area.
- The practice is responsive. The appointment system was guided by internal audit and evaluation of the needs and views of the patients. Urgent needs were addressed on the day and the patients in general were able to see the GP of their choice. Although some expressed concern about not being able to see the GP

Summary of findings

of their choice at a time convenient for them. The service had positive working relationships between staff and other healthcare professionals involved in the delivery of service.

- The practice is well led. The management team reflected upon the services they provided and actively explored ways of improving health and care outcomes. Quality and performance was monitored and risks were identified and managed.

We saw several areas of outstanding practice including:

- The practice as part of SHIELD (The Selby Area Federation of GP Practices) had won an innovation fund, to develop social prescribing. This fund was used initially to support the local voluntary service to produce an up to date data base of available voluntary social care organisations. Patients were then referred to the most appropriate services.
- The practice was pro-active and reactive to managing patient access, their needs and expectations. All patients who wanted a same day appointment were called back and only triaged by the GP. Over 75 years of age patients always had a same day appointment if needed.
- The practice used the term Query–Doc for the GP who had a shortened morning surgery to ensure all correspondence was read and dealt with on the day. This assured any changing or emerging health needs of patients were responded to effectively and efficiently.

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. There was a genuine open culture in which all safety concerns raised by staff and patients who used the service were highly valued, as integral to learning and improvement. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. The practice was well staffed and this ensured that patients were safe when receiving care.

Are services effective?

Good

The practice is rated as good for effective services. Our findings at inspection showed systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We saw evidence to confirm these guidelines were positively influencing and improving practice and outcomes for patients. The practice was using innovative and proactive methods to improve patient outcomes and linked with other local providers to share best practice. We saw collaborative working with multi-disciplinary teams to reduce unplanned admissions to secondary care (hospitals). This pro-active approach had significantly reduced admissions and improved patient health outcomes.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive about the compassionate and sensitive care they received. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found positive examples to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders were positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They acted on suggestions for improvements and changed the way they delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its

Summary of findings

local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. Patients were able to access a wide range of services at the practice, which enabled patients to be treated nearer to their home.

Some patients told us it was not always easy to get an appointment with a named GP or a GP of their choice. However we were told of positive actions taken to improve appointment availability, the detail is within the report. Urgent appointments were available the same day and we were told patients were not turned away. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available, however not displayed in the waiting rooms. Evidence we saw showed the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders where appropriate.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a vision with quality and safety as its top priority. However very few staff could detail this to us. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a level of constructive engagement with staff. Staff had received inductions, regular performance reviews and attended staff meetings and events.

We found a high level of staff satisfaction. The practice gathered feedback from patients in a variety of formats and they had a very active patient participation group (PPG). We saw evidence of changes which were made as a result of patient feedback, which included having a duty doctor working each day to triage patients who wanted to be seen the same day.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients. The practice offered proactive, personalised care to meet their needs. Nationally reported Quality Outcomes Framework (QOF) data showed the practice had good outcomes for conditions commonly found in this age group. The practice was responsive to their needs, understanding the impact of the rural environment for their patients. They provided annual health checks for elderly patients and where suitable home visits. In addition they provided weekly visits and annual health checks for patients living in the local care homes. They followed up those patients who had been discharged from hospital.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. Each patient had a personalised care plan including agreed goals to support patients with self-care and health improvement. 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. These patients had a named GP and a structured annual review to check their health and medication needs were being met. 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. The nationally reported Quality Outcomes Framework (QOF) showed 100% achievements in all but one of these conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. Joint appointments were given to all post-natal mothers and their babies for their appropriate health checks. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and

Summary of findings

pregnant women whose health deteriorated suddenly. The practice provided contraceptive and sexual health support at specific women's health clinics. There were named GPs who ensured continuity of treatment and care to these patients.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students). The needs of these patients had been identified and the practice had adjusted the services it offered to ensure they were accessible, flexible and offered continuity of care. They were able to access timely appointments to meet their specific needs. Every Saturday morning there were pre-bookable GP appointments available for this patient group. The practice was proactive in offering online appointment booking and repeat prescription requests. There was a full range of health promotion leaflets and health screening which met the needs for this age group. This included NHS health checks for identified groups.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may result in them being vulnerable. We were told these patients were never turned away. Links had been made with local health and social care teams and joint monthly patient review meetings took place to discuss the most vulnerable patients. The practice held a register of patients with learning disabilities and offered them annual health checks and longer appointment times. Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for patients who experience poor mental health (including patients with dementia). Practice staff were aware of their patients with poor mental health and offered support to meet their needs. All patients experiencing poor mental health received an annual physical health check. The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health. However the specialised service who provided further support for these patients did not meet their needs in a timely way.

Summary of findings

The practice had signed up for specialist training in dementia. All staff were to attend this training in July 2015, when the practice would be closed. This would help to assure all practice staff were able to provide the most up to date care and support for this patient group.

Arrangements were in place for dispensing staff to flag up any concerns regarding over or under ordering of medicines and staff worked to a Standard Operating Procedure for patients on certain medicines. The practice had told patients experiencing poor mental health how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

We received 24 CQC patient comments cards where we found very positive comments about the practice and the staff. We saw comments about the excellent care patients and their families had received from members of the clinical team. Three patients described their excellent care and treatment in emergency situations. All patients described being involved in all aspects of their care and how the GPs and nurses explained everything to them. Some of the comments were from people who had been patients for over 30 years.

The friends and family test report showed the patients who had completed the forms were more than happy with the care and treatment they received from the range of practice staff.

We spoke with 11 patients, from different population groups, including one member of the Patient Participation Group. They told us the staff were very helpful, respectful and supportive of their needs. They felt everyone communicated well with them; they were involved and felt supported in decisions about their care. They felt the clinical staff responded to their treatment needs and they were provided with a caring service. However all commented about the lack of available appointments at times and with a preferred doctor.

The National GP Patient Survey results (an independent survey run by Ipsos MORI on behalf of NHS England) published on 8 January 2015 showed the practice scored highly against national averages. There were 257 survey forms distributed for Tadcaster Medical Centre and 122 forms were returned. This was a response rate of 47.5% of the forms distributed. Statistically this number equates to 1.5 % of the total practice population.

Some of the most recent patient survey results showed:

- 98.4% of respondents to the GP patient survey had confidence and trust in the last GP they saw or spoke to; compared to the local CCG average of 94.1% and 92.2% the national average.
- 92.3% of respondents to the GP patient survey who described the last GP they saw or spoke to was good at giving them enough time. Compared to the local CCG average of 87.2% and 85.3% the national average.
- 88.5% of respondents to the GP patient survey had confidence and trust in the last nurse they saw or spoke to; compared to the local CCG average of 87.8% and 85.5% the national average.
- 45.2% of respondents to the GP patient survey with a preferred GP usually get to see or speak to that GP. Compared to the local CCG average of 50.2% and 53.5% the national average.

Outstanding practice

- The practice as part of SHIELD (The Selby Area Federation of GP Practices) had won an innovation fund, to develop social prescribing. This fund was used to support the local voluntary service to produce an up to date data base of available voluntary social care organisations. Patients were then referred to the most appropriate services.
- The practice was pro-active and reactive to managing patient access, their needs and expectations. All patients who wanted a same day appointment were called back and only triaged by the GP. Over 75 years of age patients always had a same day appointment if needed.
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Tadcaster Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP Specialist Advisor (SpA),a Pharmacist SpA , a CQC inspector and an expert by experience.

Background to Tadcaster Medical Centre

The Tadcaster Medical Centre is located in a purpose built building next to the local bus station. The practice provides Personal Medical Services (PMS) under a contract with NHS England, North Yorkshire and Humber Area Team, to the practice population of 8,359 patients. This is a training practice for qualified doctors who wish to undertake the postgraduate qualifications to become a GP.

The practice is a dispensing practice. There is a mix of male and female staff at the practice. Staffing at the practice is made up of five GP partners (four female and one male), one salaried GP (male). There is one female advanced nurse practitioner, one female practice nurse and two female health technicians. There is a practice manager, dispensing staff and a range of administration and secretarial staff.

The practice is open between 8.30 am and 6pm Monday to Friday. The dispensary is closed each day between 12.30pm and 1.30pm. The surgery and dispensary are open every Saturday morning. The appointments are pre-bookable GP only, from 8am until 12.30 pm. This extended hours service is to help patients access the GP at a more convenient time for them.

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.

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

Before visiting, we reviewed a range of information we held about the practice and asked other organisations such as healthwatch, to share what they knew. We carried out an announced visit on 2 June 2015. During our visit we spoke with 12 members of staff, these included GPs, a GP registrar, the practice manager, dispensing staff, nurse practitioner, practice nurse, secretaries and reception staff. We spoke with patients who used the service and a member of the Patient Participation Group (PPG). We observed how people were being cared for and talked with carers and/or family members. We reviewed comment cards where patients shared their views and experiences of the service.

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

- Is it safe?

Detailed findings

- 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)

Good

Are services safe?

Our findings

Safe track record

The practice had systems in place to record, monitor and learn from incidents which had occurred within the practice. Safety was monitored using information from a range of sources. These included the Quality and Outcomes Framework (QOF), patient survey results, the Patient Participation Group (PPG), clinical audits, professional development, and education and training.

Staff were able to give examples of the processes used to report, record and learn from incidents. They confirmed these were discussed in the clinical, management meetings and with relevant staff. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. 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 year and we were able to review these. Significant events were a standing item on the clinical practice meeting agenda and a dedicated meeting was held six monthly to review actions from past significant events and complaints. There was evidence the practice had learned from these and the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at their meetings and they felt encouraged to do so.

Staff used incident forms and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked six incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of the wrong prescription being issued to a patient with a similar name. The actions and investigations were detailed and protocols were revisited. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated to practice staff by email, on-line tasks or in meetings. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They confirmed alerts were discussed in clinical meetings to ensure staff were aware of any relevant to their practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

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

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. This was to ensure risks to children and young patients, who were looked after or on child protection plans, were known and reviewed. We were told there was frequent liaison with partner agencies such as, health visitors and social services.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff, who were trained, would act as a chaperone if nursing staff were not available. They understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Good

Are services safe?

Medicines management

We checked procedures for medicines management and these were available for each process undertaken by staff in the dispensary. We found staff signed and dated the procedures to confirm that they had read them. We checked medicines stored in the dispensary, treatment room and medicine refrigerators. There was a clear policy for ensuring medicines were kept at the required temperature. We found that storage was safe and secure, and medicines were within their expiry dates. Medicines were stored at the correct temperature so that they were fit for use. The temperature of the medicines refrigerators and the dispensary were monitored daily. There was a system to check the emergency medicines to ensure the correct stock level and expiry dates.

Patients were able to order their repeat prescriptions in person, in writing using the medicines list on the prescription counterfoil, on-line, or by using a mobile phone 'app'. There were strict processes in place so staff could only issue repeat prescriptions and dispense medicines, which were up-to-date on the repeat prescription record. Only GPs and the Nurse Practitioner were able to make changes to repeat prescription records for example, after discharge from hospital or following medication review. Dispensary staff were able to make changes to repeat prescription records for stoma products only in line with dispensary procedures. Reception staff issued prescriptions for patients to take to their local pharmacy, and dispensary staff issued prescriptions and dispensed medicines for those eligible for 'doctor dispensing'. Staff explained how they made checks for compliance such as by checking under-ordering or over-ordering of medicines and how these concerns were raised with GPs.

The procedure for ensuring prescriptions were signed by the GP before patients received their dispensed medicines was recently reviewed. Patients only received dispensed medicines after a GP had checked and signed the prescription. The dispensary used a 'bar code' system so that dispensed medicines were matched with the prescription electronically to reduce the risk of the wrong medicine being dispensed.

We discussed the management of high risk medicines, such as the blood thinning medicine called warfarin, with the GP. They explained the audit processes in place to make sure that patients attended for regular monitoring so that repeat prescriptions could be issued safely.

We checked the arrangements for storing blank prescriptions. These needed to be kept secure to prevent mishandling, diversion and misuse. We found that these were locked away but there was no audit trail in place. We discussed this with the practice manager who was in the process of implementing a system of accounting for prescriptions. We discussed the arrangements for managing national alerts relating to medicines, for example when medicines had to be removed from use due to manufacturing quality issues. The dispensary staff explained how these alerts were processed but there was no record of those that had been done recently. The practice manager was implementing a new system to record the action taken to confirm that they had been dealt with.

Medicines liable to misuse, called Controlled Drugs, were managed safely. Standard operating procedures were in place for managing Controlled Drugs that were recently reviewed. The keys for the Controlled Drugs cabinet were secure and accessible only to designated staff. There were systems for recording and disposing of out-of-date or unwanted Controlled Drugs. Staff were aware of how to raise concerns with the Controlled Drugs Accountable Officer in their area.

Staff who dispensed medicines were appropriately trained and had the necessary experience to undertake the task safely. The practice manager told us that the practice was signed up to the Dispensing Services Quality Scheme (DSQS) this rewards practices for providing high quality services to patients of their dispensary. The GP who took the lead for the dispensary undertook competency checks of dispensers in line with the DSQS competency template.

The nurse practitioner and the practice nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directions and evidence that nurses had received appropriate training to administer vaccines. A member of the nursing staff was

qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

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.

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 and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed. We saw the action plan to replace the carpets in the consulting rooms to comply with current guidance. The infection control lead told us 'wet procedures' were only undertaken in rooms with appropriate flooring which could be cleaned to approved standards

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

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

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. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices.

Staffing and recruitment

Records we looked at contained evidence 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 setting out the standards it followed when recruiting clinical and non-clinical staff.

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. 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. We were told of succession planning and a recent recruit to the nursing team. In addition we were told by the nurse practitioner of the innovative way they changed the nursing provision within the practice. A member of the team left and the roles were then broken down, differently. This initially freed up appointments when the newly recruited health technicians were trained to monitor new patient checks, undertake electrocardiograms (ECGs) and blood pressure monitoring and one is now a trained phlebotomist. The practice nurse had specific roles which included cervical smears and vaccinations. Another treatment room nurse was newly recruited to complement this role. This meant the nurse practitioner concentrated on managing and monitoring patients with Long Term Conditions as well as treating minor illness and injury.

Good

Are services safe?

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, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw all risks were discussed at GP partners' meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

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

A business continuity plan was in place to deal with a range of emergencies which may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. We were told of when they had to successfully implement this plan. Tadcaster was flooded and it impacted on the medical centre, however, the service was delivered differently and all patients were seen and medications dispensed as required.

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.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The GPs told us they lead in specialist clinical areas such as diabetes, paediatrics, minor surgery, heart disease, substance misuse and asthma. The nurse practitioner, the practice nurse and the health technicians 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. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders and diabetes, which were prevalent in the practice population. Our review of the clinical meeting minutes confirmed that this happened.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (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, we saw an audit regarding the prescribing of aspirin. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

We saw data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular reviews. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within the week by their GP according to need.

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 suspected cancers. Patients had to be seen by specialists within two weeks of being seen by their GP. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and improvements to practice were shared with all clinical staff.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us four clinical audits that had been undertaken in the last two years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. We looked specifically at two completed audit cycles where the practice was able to demonstrate the changes since the initial audit. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. All the audits demonstrated improved outcomes for

Good

Are services effective?

(for example, treatment is effective)

patients. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (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, we saw an audit regarding the required monitoring of blood analysis when prescribing Disease Modifying Anti-Rheumatic drugs (DMARDS), all patients who had their health managed at the practice had, had their blood screening completed. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 100% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ 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. They documented any changes necessary to each patient's records. 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. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

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.

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 annual basic life support. We noted a good skill mix among the doctors with additional diplomas in sexual and reproductive medicine, and diplomas in children's health and obstetrics, diabetes and respiratory diseases. All GPs were up to date with their annual continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). In addition the practice had introduced peer review sessions for GPs. They had protected time to review cases, to learn from and with each other, a technique from the GP training scheme which they felt benefited all GPs.

All staff undertook annual appraisals where learning needs were identified and action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses, for example two members of administration staff had recently undertaken courses which included 'handling difficult conversations'. 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 trainee we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, and cervical cytology. The Nurse Practitioner with an extended role saw patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease and they were able to demonstrate they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

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 NHS 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

We saw the policy for actioning hospital communications was working well as they used a GP who had a shorter morning surgery as 'Query-Doc'. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held monthly multidisciplinary team meetings 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 reported to be well attended by district nurses, social workers, 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 the forum as a means of sharing important information. They were very clear they talked about patients and not tasks.

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, Choose and Book had now been replaced with Referral Support Service (RSS). Staff reported this system was easy to use and they felt it was better for patients.

The practice had signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). This will be in place by November 2015.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

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 with 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) and had a section stating the patient's preferences for treatment and decisions. 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.

Good

Are services effective?

(for example, treatment is effective)

All clinical staff demonstrated a clear understanding of Gillick competencies. (Used to help assess whether a child had the maturity to make decisions about their care and treatment and to understand the implications of these decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

The practice as part of SHIELD (The Selby Area Federation of GP Practices) had won an innovation fund, to develop social prescribing. This fund was used to support the local voluntary service to produce an up-to-date, data base of available voluntary social care organisations. Patients were then referred to the most appropriate services; this innovation was in its infancy. The database had been completed in May 2015.

It was practice policy to offer a health check with the health technician / practice nurse to all new patients registering with the practice. 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 to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that over 50% of patients in this age group had taken up the offer of the health check. 53 patients had been identified as high risk after their screening. A GP showed us how patients were followed up within one week if they had risk factors for disease identified at the health check and how they scheduled further investigations. These patients were now being treated for their identified needs.

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. 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.

The practice's performance for cervical smear uptake was 88.2 %, which was better than 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 did not attend. There was also a named nurse responsible for following up patients who did not attend screening. Performance for national chlamydia, mammography and bowel cancer screening in the area were all above average for the CCG and a similar mechanism of following up patients who did not attend was also used for these screening programmes.

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.

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 published in January 2015, a survey of 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. The practice rated highly for its satisfaction scores on consultations with doctors and nurses with 92.3% of practice respondents saying the GP was good at listening to them and 98.4% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 24 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with 11 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Three told us of the exceptional 'service' they received in emergency situations. They felt the doctors went beyond the call of duty to ensure their health and well-being.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Disposable 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 conversations taking place in these rooms could not be overheard.

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. In response to patient, PPG and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This helped to prevent patients 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. We were also told how the waiting room chairs had been moved away from the reception desk to further maintain privacy and dignity, at the suggestion of the PPG's patient feedback.

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.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 82.5% of practice respondents said the GP involved them in care decisions and 83.2% felt the GP was good at explaining treatment and results. Both these results were similar to others in the CCG and higher than the national average. The results from the practice's own satisfaction survey showed the majority of patients said they were sufficiently involved in making decisions about their care.

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 felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also very positive and aligned with these views.

We saw anonymised care plans for patients with long term conditions, detailing their involvement and agreement to life style changes where necessary; we saw the review date appointments.

Good

Are services caring?

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

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. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this information. For example, we were told how a GP called at a patients home immediately after a family member had died unexpectedly. This level of support continued and it was obviously felt important for us to be told at inspection. Other examples of emotional care and support were identified to us by very appreciative patients; who could not praise the GPs highly enough.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Notices in the patient waiting room, and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

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.

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. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. This included the six federated GP practices who had looked at the service provision of voluntary support in this semi-rural area and had won funding to ensure an up-to-date information about these services was available. The local volunteer service would take referrals and support patients in need to access the most appropriate for them.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). These included better access to the practice, a hand rail and automated door. Reviews of the appointment systems, the changes have been implemented and this included the duty doctor call back service, which is highly commended by all patients who were either spoken with or had been in touch with us.

Tackling inequity and promoting equality

The practice was situated on the ground floor. Consulting rooms and corridors were accessible to all patients which made movement around the practice easy and helped to maintain patients' independence. We saw the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. The seats in the waiting area were of different heights and sizes allowing for diversity in physical health. An audio loop was available for patients who were hard of hearing. In addition there was a member of staff who used sign language; patients who were hard of hearing were mainly booked in when this member of staff was available. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. Records showed regular tests were carried out on the emergency call bell facilities. Parking was available for all patients.

The practice had access to online and telephone translation services.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

The homeless population was one self-styled 'man of the road' who visited intermittently over the summer. He knew he could walk in and wait to be seen. The GPs prescribed, arranged review appointments and had attempted to arrange more support via the vicar locally.

Access to the service

Appointments were available from 8.30am to 5.50pm on weekdays. The practice's extended opening hours was particularly useful to patients with work commitments. These were pre-booked appointments every Saturday from 8.00am until 12.15pm. The dispensary was open every week day as well as Saturday mornings. However, the dispensary is closed each week day between 12.30pm until 1.30pm. Urgent same day appointments were available. The on-call GP would ring the patient /carer back; the reception staff did not triage patients. Appointments were released at varying times and this information had been well publicised.

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, the telephone automated system, in person or by telephone. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information about the out-of-hours service was provided to patients.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

visits were made to the local care home on a specific day each week, by a named GP and to those patients who needed one. Appointments were made available for children of school age after school hours.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

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

We did not see information displayed in the waiting room to help patients understand the complaints system. However, the information was on the practice's website. Some of the patients we spoke with were aware of the process to follow if they wished to make a complaint. We drew this to the practice's attention at the inspection. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 19 complaints received in the last 12 months and found they had been dealt with in a timely way and were open and transparent. There was an active review of complaints and where appropriate improvements made as a result. Positive feedback from patients was also shared and celebrated among the staff.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

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. These values were not clearly displayed in the waiting areas or the staff room. The practice vision and values was not known by any of the 11 staff members we spoke with. We brought this to the practice manager's attention.

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 10 of these policies and procedures. All 10 policies and procedures we looked at 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 there was a named GP as the lead for safeguarding. We spoke with 11 members of staff and they were all clear about their own roles and responsibilities. They all told us they knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and their systems to identify where action should be taken. These included reviews of new cancer diagnoses in line with national referrals and audits triggered by national guidance alerts.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues. We saw that the risk log was regularly discussed at team 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.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. 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. However most of the staff we spoke with felt they would value a 'whole practice team' meeting if only once a year. We drew this to the practice manager's attention.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, such as confidentiality policy which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patients' surveys, 360 degree feedback (each GP when revalidated is expected to provide evidence of feedback from colleagues and patients) and the friends and family test which was available in the waiting area.

The practice had an active patient participation group (PPG). The PPG included representatives from various population groups. The PPG had carried out surveys and met regularly. The practice manager showed us 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.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. 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 staff files and saw regular appraisals took place. We were told and were provided with examples where staff had been supported to complete additional training. This was to support their professional development and also enhance the care offered to patients.

Are services well-led?

Good

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

The practice was a GP training practice for post-graduate doctors we were told the support and development they were given was exemplary.

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