# Spa Surgery

## Quality Report

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Date of inspection visit: 14 July 2015
Date of publication: 10/09/2015

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? | Requires improvement |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Good |

# Summary of findings

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## Overall summary

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

We carried out an announced comprehensive inspection at Spa Practice on 14 July 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff told us they had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said there was continuity of care, with urgent appointments available the same day.
- There was a clear leadership structure and staff felt supported by the partnership. The practice proactively sought feedback from staff and patients, which it acted on.
- Some risks to patients were assessed and managed, with the exception of those relating to recruitment checks and legionella testing

However, there were areas of practice where the provider should make improvements.

- Ensure recruitment arrangements include all necessary pre-employment checks.
- Ensure a legionella test is completed and action plan implemented in accordance with the findings.
- Ensure risk assessments are appropriately documented and recorded and updated as necessary.
- Keep a record of all training and updates staff attend.

# Summary of findings

- Comply with fire safety regulations by performing fire evacuation drills as required.

**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?**

**Requires improvement**

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong, reviews and investigations were thorough enough and lessons learned were communicated across the team to support improvement. Although some risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, pre-employment recruitment checks, legionella testing and staff training records required improvement.

**Are services effective?**

**Good**

The practice is rated as good for providing effective services. Data showed patient outcomes were comparable to the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

**Are services caring?**

**Good**

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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

**Good**

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Local Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients told us there was continuity of care, with urgent appointments available the same day. Information about how to

# Summary of findings

complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

**Are services well-led?**

Good

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

# Summary of findings

## The six population groups and what we found

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

**Older people**

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. In partnership with other practices in the area the practice co-funded a community nurse team to care for patients in their own homes.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. Practice nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk; for example, children and young people who had a high number of accident and emergency attendances. 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. We saw good examples of joint working with midwives, health visitors and school nurses.

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

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

# Summary of findings

to ensure these were accessible and offered continuity of care. The practice was proactive in offering online services as well as a full 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 living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and all had received a follow-up for the current year. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of people whose circumstances may make them vulnerable. Patients were supported to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in patients. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Of those people experiencing poor mental health, 94% had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

# Summary of findings

## What people who use the service say

The National GP Patient Survey results published on July 2015 showed the practice was performing in line with local and national averages. There were 123 responses which represents a 48% response rate to the survey.

- 66% found it easy to get through to this surgery by phone compared with a CCG average of 79% and a national average of 73%.
- 84% found the receptionists at this surgery helpful compared with a CCG average of 88% and a national average of 87%.
- 82% with a preferred GP usually got to see or speak to that GP compared with a CCG and national average of 60%.
- 89% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 86% and a national average of 85%.
- 93% say the last appointment they got was convenient compared with a CCG and national average of 92%.
- 72% described their experience of making an appointment as good compared with a CCG average of 77% and a national average of 73%.
- 85% usually waited 15 minutes or less after their appointment time to be seen compared with a CCG average of 72% and a national average of 65%.
- 81% felt they did not normally have to wait too long to be seen compared with a CCG average of 61% and a national average of 58%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 28 completed cards, all were very 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. Two comments were less positive relating to getting through to the practice first thing in the morning by telephone. We spoke with four patient participation group members prior to the inspection and six patients on the day of our inspection. All told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

## Areas for improvement

**Action the service SHOULD take to improve**

- Ensure recruitment arrangements include all necessary pre-employment checks.
- Ensure a legionella risk assessment action is completed in accordance with the findings.
- Ensure risk assessments are appropriately documented and recorded and updated as necessary.
- Keep a record of all training and updates staff attend.
- Comply with fire safety regulations by performing fire evacuation drills as required.

# Spa Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector and the team included a second CQC inspector, a GP specialist advisor and a practice manager specialist advisor.

## Background to Spa Surgery

Spa Surgery is located in the village of Boston Spa on the outskirts of Wetherby. The practice provides services for 6724 patients under the terms of the locally agreed NHS General Medical Services contract. The practice catchment area is classed as within the group of the least deprived areas in England. The age profile of the practice population differs to other GP practices in the Leeds North Clinical Commissioning Group (CCG) area as there are more patients registered at the practice over the age groups of 65 years old, 75 years old and 85 years old and less between 15 years old to 34 years old.

There are four GP partners, two male and two female, who work at the practice. They are supported by a male salaried GP, an advanced nurse practitioner, five practice nurses, one healthcare assistant, a practice manager and a team of administrative staff.

The practice is open weekdays from 8am to 6pm. Calls to the practice between 6pm to 6.30pm are answered by the out-of-hours service. Appointments with GPs were available from 8.30am to 11.30am and 2pm to 5.30pm. Practice nurse appointments are available from 9am to 12.40pm and 2pm to 5.30pm. Patients contacting the practice for an urgent appointment would speak to the on call GP and an appointment arranged that day if needed. Diabetic, asthma, coronary heart disease, antenatal and mother & baby clinics are run each week. Out-of-hours care is provided by Local Care Direct and is accessed via the surgery telephone number or by calling the NHS 111 service. Patients can choose to be seen in Leeds or at Harrogate Hospital during the out-of-hours period.

Spa Surgery is registered to provide; diagnostic and screening procedures, family planning, maternity and midwifery services and the treatment of disease, disorder or injury from Spa Surgery, 205 High Street, Boston Spa, Wetherby, LS23 6PY.

## 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 registered 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 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 information we hold about the practice and asked Leeds North Clinical Commissioning Group (CCG) and NHS England to share what they knew. We carried out an announced visit on 14 July 2015. During our visit we spoke with four GPs, the practice manager, two

# Detailed findings

practice nurses and six members of the administrative team. We also spoke with 10 patients who used the service.. We observed how staff communicated with patients, we talked with carers and/or family members and reviewed the personal care and treatment records of patients. We reviewed 28 CQC comment cards where patients and members of the public 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?
- 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)

Requires improvement

# Are services safe?

## Our findings

### Safe track record

The practice used information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, the procedure for scanning documents on to the electronic patient record system was reviewed following an incident where a patient's scan results were uploaded to another patient's record. Staff we spoke with could tell us the recent change to this procedure.

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 could show evidence of a safe track record over the long term.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of 16 significant events which had occurred during the last year and saw this system was followed appropriately. Significant events were a standing item on the weekly practice meeting agenda and progress was reviewed monthly at the business partner meetings. 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 the meetings and they felt encouraged to do so.

Staff reported incidents to the practice manager who then completed an incident form on the risk management reporting system. We were shown the system used to manage and monitor incidents. We tracked 16 incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and the learning had been shared. For example, for staff to check three pieces of patient identifiable information when booking a patient into an appointment. This was to prevent a patient with the same name being incorrectly booked into the appointment. Where patients had been affected by something which had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts which were relevant to the care they were responsible for. They also told us alerts were discussed at the weekly practice meeting and a lead person was then nominated to take further action if required. The lead would then cascade relevant information and actions to the different staff groups.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to those whose circumstances may make them vulnerable. 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 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 the lead in safeguarding adults and children. They had been trained to level three in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil the roles. 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 those whose circumstances made them vulnerable on the practice electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example, children subject to child protection plans or those living in supported accommodation. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to

children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP demonstrated good liaison with partner agencies such as the police and social services. Staff were proactive in monitoring if children or adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (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 practice nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. We noted not all staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

We were told by the practice manager the remaining DBS checks would be completed as a priority.

### Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. We were shown two incident reports where there had been an interruption of the electricity to the vaccine fridges. We saw from the documentation staff had taken the appropriate action reporting the incident to Public Health England and appropriate disposal of the vaccines. Actions were taken to prevent any further disruption of power to the fridges. For example, labelling the plug to ensure it was not accidentally turned off.

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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were kept securely but were not tracked through the practice. We reported this to the practice manager who told us the procedure would be reviewed in line NHS Protect prescription security guidance.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They carried out regular audits of the prescribing of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The practice nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines which had been produced in line with legal requirements and national guidance. We saw sets of PGDs which had been updated in 2014. In practice this means that a PGD, signed by a doctor and agreed by a pharmacist, can act as a direction to a nurse to supply and/or administer prescription-only medicines (POMs) to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription. The healthcare assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) which had been produced by the prescriber. A PSD is a written instruction, signed by a doctor, dentist, or non-medical prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis. We saw evidence practice nurses and the healthcare assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber. A member of the nursing staff was

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

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures which set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

The practice had established a service were prescriptions were sent to the patient's choice of chemist. Staff had systems in place to monitor how these prescriptions were collected from the practice. They also had arrangements in place to ensure patients collecting medicines from these locations were given all the relevant information they required.

### Cleanliness and infection prevention and 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.

An infection prevention and control (IPC) 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. Staff were able to describe how they would use these to comply with the IPC policy. For example, reception staff told us when they would use gloves and aprons when accepting specimens from patients. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for IPC who had undertaken further training to enable them to provide advice and carry out staff training. Staff we spoke with told us they received induction training about infection control specific to their role and received annual updates. We saw evidence an IPC audit was completed in January 2014. We noted some improvements identified for action relating to furnishings had not yet been reviewed. For example, replacing the blinds in the clinical areas. The practice manager told us these were included in the building improvement plan.

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 completed a risk assessment for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). A legionella risk assessment was last performed in May 2013. We noted only some of the actions recorded in the risk assessment were documented as completed.

### Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was January 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment was completed in June 2015. For example, weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer had been calibrated.

### Staffing and recruitment

The practice had a recruitment policy which set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained some evidence appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. We noted the practice did not follow its recruitment policy as two staff files we looked at did not

contain pre-employment checks. For example, references or evidence of professional registration. We fed this back to the practice manager and registered manager who told us this would be looked into.

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 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. Newly appointed staff had this expectation written in their contracts. The practice had an arrangement with other practices in their CCG cluster group for staff to work at the practice to cover absence at short notice if required.

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. The practice manager showed us records to demonstrate actual staffing levels and skill mix met planned staffing requirements.

### 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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice manager told us they completed a weekly walk around of the building to identify anything which was amiss and to agree action to rectify it. We were told this process was not documented. We were shown the health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice manager told us a recent fire risk assessment had been completed and they were waiting for the assessment and action plan to be sent to the practice. We were shown evidence the fire equipment was tested every six months and were told staff had completed fire safety training. We were told a fire evacuation drill had not been performed in the last year. The practice manager told us this would be reviewed in line with fire safety procedures.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff told us they had attended recent update training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). Staff could tell us the location of the equipment and records confirmed it was checked regularly.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included adrenaline (which can be used to treat anaphylaxis); hydrocortisone (for treating asthma or recurrent anaphylaxis). 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. The plan was last reviewed in July 2015.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and practice nurses 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 guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and practice nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

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

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines; for example, introducing the year of care for diabetic patients. Our review of the clinical meeting minutes confirmed this happened.

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

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed the culture in the practice was 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

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. 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 undertaken in the last two years. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. 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 a follow up blood test after patients taking blood thinning medicines were prescribed antibiotics. Following the audit, the GPs told patients who were prescribed antibiotics and taking blood thinning medications to arrange a blood test seven days after they completed the course of antibiotics. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

Other examples of clinical audits included reviews to confirm the GPs who undertook contraceptive implants and the insertion of intrauterine contraceptive devices were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

Good

# Are services effective?

## (for example, treatment is effective)

Staff used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice achieved 93% of the total QOF target in 2014, which was just below the CCG average of 97% and national average of 94%. Specific examples to demonstrate this included:

- Performance for diabetes care was lower than the CCG and national average.
- The percentage of patients with high blood pressure having regular blood pressure tests was lower than the CCG and national average
- Performance for mental health care was higher than the CCG and national average.
- The dementia diagnosis rate was higher than the CCG national average

The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed. For example, introducing the year of care for diabetic patients. The year of care approach aims to transform annual reviews into a collaborative care planning consultation with a partnership approach between the health professional and patient.

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.

The prescribing rates for the practice were better than national figures particularly with less antibiotics being prescribed. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long term conditions such as diabetes and the latest prescribing guidance was being used.

The electronic patient record system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence after receiving an alert the GPs would review the use of the medicine in question. Where they continued to prescribe it they would outline the reason why they decided this was necessary in the patient notes.

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

The practice kept a register of patients identified as being at high risk of admission to hospital and of those whose circumstances may make them vulnerable. Structured annual reviews were also undertaken for people with long term conditions. For example, diabetes, chronic obstructive pulmonary disease (COPD) and heart failure.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. This benchmarking data showed the practice had outcomes were comparable to other services in the area. For example, indicators for cancer care showed the practice referred patients to specialist services within the two week wait times.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We asked to see staff training records. We were told the practice did not have a copy of all the training staff at the practice had completed. We were told by the practice manager and staff they had attended recent mandatory courses such as annual basic life support.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses; for example, staff/receptionists had completed a medical terminology course.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence they were trained appropriately to fulfil these duties. For example, on administration of vaccines

and cervical cytology. Those with extended roles who saw patients with long term conditions such as asthma, chronic obstructive pulmonary disease (COPD) and diabetes were also able to demonstrate they had appropriate training to fulfil these roles.

Staff files we reviewed showed 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 patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospitals including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of-hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within three days of receipt. The GP who saw these documents and results was responsible for the action required. All of the GPs had access to each other's communications and could provide assistance if 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 which were not followed up.

Emergency hospital admission rates for the practice were relatively low at 13% compared to the national average of 14%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and no follow-ups were missed.

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs. For example, those with multiple long term conditions, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

### 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. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence audits had been carried out to assess the completeness of these records and action had been taken to address any shortcomings identified.

### Consent to care and treatment

We found 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. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those living 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. Of those with a dementia care plan 84% had been reviewed in last year. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have

capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for joint injections, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. Written consent was also obtained and all staff were clear about when to ask for written consent.

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

### Health promotion and prevention

It was policy to offer a health check 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. We were told the practice achieved the number of health checks they identified for patients in this age group for the year 2014. We were shown the process for following up patients within two weeks if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice's performance for the cervical screening programme was 84%, which was higher than the CCG average of 76% and national average of 77%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was just below average for the majority of vaccinations where comparative data was available. For example, flu vaccination rates for the over 65s were 3% lower than the local average and at risk groups 4% lower.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. They told us they would refer patients to local third sector organisations to access social prescribing and a dementia café was held weekly behind the practice in the church hall. 'Third sector organisations' is a term used to describe the range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, mutuals and co-operatives.

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 GP patient survey in July 2015 (48% response rate).

The evidence showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. For example, data from the national GP patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good.

The practice was also well above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 99% said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%.
- 99% said the GP gave them enough time compared to the CCG average of 88% and national average of 87%.
- 99% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 97% said the nurse was good at listening to them compared to the CCG and national average of 91%.
- 98% said the nurse gave them enough time compared to the CCG average and national average of 92%.
- 100% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and national average of 97%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 28 completed cards, all were very 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. Two comments were less positive relating to getting through to the practice first thing in the morning by telephone. We also spoke with four patient participation group members prior to the inspection and spoke with six patients on the day of our inspection. All told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so privacy and dignity was maintained during examinations, investigations and treatments. We noted 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 confidentiality policy when discussing treatments with patients in the reception area so confidential information was kept private. The practice switchboard was located in a separate room behind the reception desk. An area to the left hand side of the reception desk shielded by the wall was available for patients to speak to reception staff. These measures prevented patients overhearing potentially private conversations between patients and reception staff. Additionally, 84% said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where a patient's privacy and dignity was not being respected, they would raise this with the practice manager. The practice manager told us they 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. Receptionists told us referring to this had helped them diffuse potentially difficult situations.

### 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:

- 95% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 95% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and national average of 81%.

Good

# Are services caring?

- 98% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 90%.
- 94% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG and national average of 85%.

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. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

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

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 97% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%.
- 95% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

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

Staff told us if families had experienced bereavement, the GP who knew the family well would contact them to offer condolences and advice on how to find a support service. Two trainee counsellors held weekly talking therapy sessions at the practice for those experiencing emotional situations.

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 patients' 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 practice contributed with other practices in the area to fund a community nurse team to provide patients with multiple conditions care in their own home. We saw minutes of meetings where this had been discussed and actions agreed to implement services to better meet the needs of the local population.

The NHS England Local Area Team and CCG told us the practice engaged regularly with them and other practices to discuss local needs and service improvements which needed to be prioritised. The practice worked very closely with other practices in the locality group and a GP was the CCG lead for that locality.

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). (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). Figures of how many telephone calls to the practice were answered by reception staff and the number of face to face interactions with patients whilst at the reception desk were displayed following a suggestion from the PPG to enlighten patients to the role of the receptionist.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities or those who requested it. The majority of the practice population were English speaking patients but access to online and telephone interpretation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The partners identified the premises needed some future modifications to meet the needs of people with assisted mobility needs. Facilities for patients were on two levels and there was no lift. The consulting rooms downstairs were accessible for patients with assisted mobility needs. We noted the external and internal entrance doors to the practice were not power assisted. The patient toilets were not access enabled as there were two entrance doors near to each other with no turning circle in between. There was a waiting area with space for wheelchairs and prams. We were told the partners had submitted a plan to secure funding which included improvements to accessibility into and within the premises. The patients and carers we spoke with did not express any concerns about accessibility within the practice.

Staff told us they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system flagging persons whose circumstances put them at risk in individual patient records.

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

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed they had completed the equality and diversity training in the last 12 months and equality and diversity was regularly discussed at staff appraisals and team events.

### Access to the service

The practice was open from 8am to 6pm Monday to Friday. Calls to the practice between 6pm and 6.30pm were answered by the out-of-hours service. Appointments with GPs were available from 8.30am to 11.30am and 2pm to 5.30pm. Practice nurse appointments were available from 9am to 12.40pm and 2pm to 5.30pm. Patients ringing for an urgent appointment would speak to the on call GP and an appointment would be arranged that day if needed.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. Patients had the choice of which out-of-hours service they visited. They could be seen at the out-of-hours centre in Leeds or at Harrogate Hospital.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 71% were satisfied with the practice's opening hours compared to the CCG average of 73% and national average of 75%.
- 71% described their experience of making an appointment as good compared to the CCG average of 76% and national average of 73%.
- 84% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 72% and national average of 65%.

We received two comment cards relating to the difficulty getting through to the practice first thing in the morning by telephone. Of the 123 respondents to the national GP survey, 66% said they could get through easily to the surgery by phone compared to the CCG average of 74% and national average of 76%. The practice manager told us they had identified telephone access was an issue and were in discussion with the telephone provider to increase the number of lines coming into the practice.

Patients we spoke with confirmed they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. Routine appointments were available for booking four weeks in advance. Comments received from patients also showed patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, we spoke with a patient who rang the practice that morning and was seen two hours later.

Appointments were available outside of school hours and the premises were suitable for children and young people. Patients we spoke with reported the online booking system was easy to use and text message reminders for appointments were sent to those people who requested it. Longer appointments were available for those who needed them and staff told us they would avoid booking appointments at busy times for those who may find it stressful.

### 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 saw information was available to help patients understand the complaints system in the practice leaflet and posters displayed in the waiting room area. 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.

We looked at five complaints received in the last 12 months and found they were satisfactorily handled, dealt with in a timely way and provided openness and transparency dealing with and responding to the complaint.

The practice reviewed complaints at the monthly business partners' meeting to detect themes or trends. Lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Staff we spoke with told us they received feedback from the learning of complaints via the practice manager as and when policies and procedures were changed.

# 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 spoke enthusiastically about working at the practice and they told us they felt valued and supported. We were told the practice had a business improvement plan that included improvements to the building and staff told us their role was to provide the best care to patients. We asked if the practice had developed an overall vision or practice values that staff had taken time out to contribute to and staff told us this happened informally between staff and managers.

### 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 five of these policies and procedures and most staff had completed a cover sheet to confirm they had read the policy and when. All five 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 a partner was the lead for safeguarding. Another partner took the lead for staff issues and another for medicines management. We spoke with 13 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.

A GP and practice manager took an active leadership role for overseeing the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw QOF data was regularly discussed at business team meetings and action plans were produced to maintain or improve outcomes.

Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed some risks. The practice manager told us they had a weekly walk around of the premises and dealt with issues as they arose. We were told this process was not documented.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, disciplinary procedures, induction policy, management of sickness which were in place to support staff. We were shown the electronic staff handbook 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. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

### Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. Staff told us they felt involved in discussions about how to run the practice and how to develop the practice. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. Staff said they felt respected, valued and supported, particularly by the partners.

Staff told us the weekly practice meeting was attended by GPs and a member of the nursing team. Nursing team meetings were held monthly. We looked at minutes from these meetings and found performance, quality and risks had been discussed. The practice did not hold a whole staff meeting and told us they met up as a team at the practice learning events.

### Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG which included representatives from various population groups. The PPG aimed to meet every quarter. The practice manager showed us the analysis of the last patient survey in 2013, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. We spoke with five members of the

# Are services well-led?

Good

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

PPG and they were very positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The practice had also gathered feedback from staff through appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us they had asked for specific training around medical terminology and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

### Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw regular appraisals took place which included a personal development plan. Staff told us the practice was very supportive of training and they attended practice learning sessions where guest speakers and trainers attended.

The practice had recently (June 2015) signed up to the General Practice Improvement Programme (GPIP) with the CCG. The aim was to provide a set of tools to problem solve within the practice and look at areas which currently did not function well. The partners were in the process of identifying areas for improvement to take forward to the start-up session planned in September.