Westgate Surgery

Quality Report

Westgate
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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 announced comprehensive inspection at Westgate Surgery on 22 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led. It was outstanding for providing services for people experiencing poor mental health. We rated the practice as good for services provided for older people, people with long term conditions, families, children and young people, working age people and people whose circumstances make them vulnerable.

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

• Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.

• Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.

• The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet people's needs.

• The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).

• The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand

• The practice had a clear vision which had patient care, quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

Summary of findings

- The practice was taking a lead role in the development of neighbourhood working with local practices and the third sector (Charities and not for profits organisations) to support people to stay in their own homes and receive the right health and social care according to their need.
- All staff in the practice was dementia friends and ensured the needs of people living with dementia were considered in all aspects of their care experience.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group. It linked with other local providers to share best practice.

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 almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. 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 many positive examples to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Summary of findings

Patients told us it was easy to get an appointment with a named GP or a GP of their choice, there was continuity of care and urgent appointments were available on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

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.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. 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 A&E attendances. Immunisation rates were extremely 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. The premises were suitable for children and babies with a defined children area with age appropriate toys and books. 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). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these

Summary of findings

were accessible, flexible and offered continuity of care. The practice was proactive in offering online services, extended hours including early mornings 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 carers and those with a learning disability. It had carried out annual health checks for people with a learning disability and these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing.

People experiencing poor mental health (including people with dementia)

Outstanding 

The practice is rated as good for the care of people experiencing poor mental health. All patients experiencing poor mental health had been offered 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 (A&E) 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.

All staff in the practice were dementia friends and ensured the needs of people living with dementia were considered in all aspects of their care experience.

Summary of findings

What people who use the service say

Information from the 121 returned survey responses from a total distributed of 256 from the NHS England Patient Survey published 8 January 2015, the 28 comment cards collected from patients in the two weeks prior to the inspection and the eight patients we spoke to on the 22 July provided very positive responses. The NHS England consistently paced the satisfaction rate above national and local (CCG) ratings. Of the 28 comment cards only one was less than favourable to the practice, while all eight patients we spoke to, including three from the PPG rated the practice as excellent.

Almost all (98.8%) of patients responding to the NHS England survey rated their overall experience with the practice as good or excellent.

Outstanding practice

The practice was taking a lead role in the development of neighbourhood working with local practices and the third sector to support people to stay in their own homes and receive the right health and social care according to their need.

All staff in the practice were dementia friends and ensured the needs of people living with dementia were considered in all aspects of their care experience.

Westgate Surgery

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, a practice manager and a further two CQC inspectors.

Background to Westgate Surgery

Otley is a West Yorkshire market town with an historic reliance on agriculture. However, many workers now commute to Leeds and Bradford, but some patients remain in very rural isolated areas. The practice falls into the second least deprived decile.

Westgate surgery is located in a purpose built building. The practice operates from a single site.

The practice has a registered population size of 5845, a number that is rising by 3% a year. The demography has a slight slant to the older age group. Since 2001 the practice has been commissioned on a PMS (Primary Medical Services) contract. The practice currently has two GP partners (both male), four salaried GP's (one male and three female), two senior practice nurses, one junior practice nurse, one health care assistant and one phlebotomist (all female). The clinical team is supported by a practice manager, and administrative team leader, two secretaries and seven receptionists.

The practice is open between 08.00am and 18.00pm Monday to Friday. Appointments are from 08.30am to 11.30am every morning and 13.30pm to 18.00pm daily. Extended hours surgeries are offered between 07.00am and 08.00am on certain pre-arranged days.

The 'out of hours' care is provided by Local Care Direct (LCD).

The practice is registered to provide the following regulated activities: Maternity and midwifery services, treatment of disease, disorder or injury, diagnostic screening and procedures, surgical procedures and family planning.

Why we carried out this inspection

We carried out a comprehensive inspection under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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.

The provider had not been inspected before under the Care Act 2014.

How we carried out this inspection

Prior to the inspection we contacted North Leeds reviewed information we hold about the practice, including data provided by the practice and comments from Leeds North CCG.

The inspection team carried out an announced visit on 22 July 2015. We spoke with four GP's and six staff. We reviewed 28 CQC comment cards that had been completed in the two weeks prior to our inspection. As part of the inspection we met with the practice manager and looked at the management records, policies and procedures.

Detailed findings

We observed how people were being cared for and talked with carers and/or family members.

We spoke with eight patients on the day including three representatives of the Patient Participation group (PPG).

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)

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we saw an incident reported of when a cardiologist telephoned to say he did not have the results of a 24 hour blood pressure (BP) reading. The patient he was seeing from the practice had not had a 24 hour BP reading attached to the referral as expected. An apology was given to the cardiologist, and a system put in place to ensure all BP readings were uploaded onto files within 24 hours and attached to referrals appropriately.

We reviewed safety records, incident reports and minutes of meetings for the last 12 months and noted that there was full discussion about these matters. 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. The practice reported a high number of low level incidents to support learning from incidents and improving practice. We reviewed records of five significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held three monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. In the incidents we reviewed we saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, we noted an incident when swabs had been found in a collection box and not sent to the laboratory on the correct day, the incident was discussed with the team and as part of the serious events analysis, and procedures were reviewed and reiterated to all staff. Checks put in place to ensure all clinical samples were sent for process on the correct day. Where patients had been affected by something that 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 emails and weekly team meetings to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the area of care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that 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 lead for safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these 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 vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or people known to be caring for another person. There was active engagement in local

safeguarding procedures and effective working with other relevant organisations. The attached Health Visitor attended the practice meeting regularly where safeguarding issues were discussed.

The practice had a system in place to identify children subject to a child protection plan. All children were known to the safeguarding lead GP and all cases were discussed at the monthly meeting with the Health Visitor. At the time of the inspection the practice had no children subject to a child protection plan. The safeguarding lead GP worked closely with the Health Visitor to monitor vulnerable children and families.

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 was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals. We saw minutes of meetings where vulnerable patients were discussed.

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 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. 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). The chaperone policy stated that the person on reception duty on a given day would not act also as chaperone to respect the dignity of the patient.

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 that 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.

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 handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. A dedicated administrator processed all repeat prescriptions.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice were similar to expected.

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 release of controlled drug prescriptions to patients was subject to extensive checks by two people.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD. 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 that set out how they were managed.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again. We saw that learning from medicine incidents were shared with local pharmacists and secondary care providers where appropriate.

On the day of the inspection we noted that two GP's had medicines in their doctors' bags in their car boots in preparation for home visits. The GP's recognised this was an error and brought their doctor's bags back into the surgery until required.

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.

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.

The practice had a lead for infection control. 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 and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium 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.

Domestic cleaning equipment was stored and managed correctly. However, we observed that there was insufficient equipment for a building that had kitchen areas, toilets, consulting rooms, waiting areas and a treatment room where minor surgery was performed. The practice agreed to look at current guidelines on appropriate cleaning equipment requirements.

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 which was within the previous 12 months. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These 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 saw the interview process for reception staff was based on the values of the practice and included team involvement. For example candidates experienced a trial in the work environment working with other members of the team.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to

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Are services safe?

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. Newly appointed staff had this expectation written in their contracts. Locum staff were used when needed to cover GP 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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements. We found high staffing levels of clinical and non-clinical staff.

Locum GP's were used in the practice and a specific locum appointment policy was in place ensuring a safe system was in place to keep patients 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 regular 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. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the log. The meeting minutes we reviewed showed risks were discussed at GP partners' meetings and within team meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, staff were able to tell us of times when they had responded to patients with various medical crisis including the sudden deterioration of long term conditions, pregnancy complications and mental health crisis.

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 in cardiac emergencies). 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 easily accessible to staff 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.

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

The practice had carried out a fire risk assessment in 2015 which included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. We saw minutes of clinical meetings which showed guidance was 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 were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead 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, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. The practice focussed on preventing hospital admissions to the top 2% of patients at risk. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

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

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 five clinical audits that had been undertaken in the last 12 months. All five of these were completed audits where the practice was able to demonstrate the completed audit cycle including re-audit over time. For example the practice undertook an audit of to confirm that the GP's who undertook minor surgical procedures, 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. The audits showed that best practice standards were being met.

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 guidelines of antibiotics. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with

Good

Are services effective?

(for example, treatment is effective)

national guidelines. 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.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 557.99 of the 559 total QOF target in 2014, which was higher the Clinical Commissioning Group (CCG) average. Performance for diabetes related indicators was better than CCG average, for example 99.02% of patients with diabetes had received influenza immunisation. The percentage of patients with known hypertension having blood pressure readings below150/90Hg in the preceding 9 months was 90.21% better than the national average of 78.53%. Performance for mental health related QOF indicators was better than the national average, for example 100% of patients with schizophrenia, bipolar disorder and other psychoses had their alcohol consumption recorded in the preceding 12 months and 93.55% had a comprehensive agreed care plan documented and recorded in the preceding 12 months. As a result patients were supported at home with a reduced incidence of emergency hospitalisation.

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 the practice had recognised two years ago their diagnosis rates for diabetes were lower than expected so an action plan was put in place to increase the number of patients screened for the condition. Over the past two years this action plan has increased the number of patients diagnosed with diabetes in the practice to be in line with similar practices.

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.

The practice's prescribing rates were similar to national figures. 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 that the latest prescribing guidance was being used. The electronic patient record system flagged up relevant medicines alerts when the GP was prescribing medicines.

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 also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as people with learning disabilities. Structured annual reviews were also undertaken for people with long term conditions and for carers.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable better than other services both locally and nationally. For example the practice had one of the highest rates for cervical cytology, 85.45% against a national rate of 81.88%, and achieving an overall 96% satisfaction rate in the patient survey which was the joint highest in the CCG.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with all attending mandatory courses such as annual basic life support. We noted a good skill mix amongst the doctors with four having additional diplomas in obstetrics and gynaecology, and three with diplomas in children's health. 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).

Good

Are services effective?

(for example, treatment is effective)

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a GP training practice, doctors who were training to be qualified as GPs offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out of hour's 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 five days of receipt. 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.

Emergency hospital admission rates for the practice were relatively similar to comparable practices at 14.16% compared to the national average of 14.4%. We saw that the policy for actioning hospital communications was working well. 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 multidisciplinary team meetings monthly to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, 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.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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 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. 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.

Good

Are services effective?

(for example, treatment is effective)

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. 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 all minor surgical procedures; 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. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

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 used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

It was practice 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 patients who smoked.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help, for example, similar mechanisms of identifying 'at risk' groups were used for patients who were caring for others and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 83.9%, which was amongst the highest in Leeds. There was a policy to offer 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 influenza vaccinations in line with current national guidance. Last year's performance was better than similar practices for the majority of immunisations where comparative data was available, for example, influenza vaccination rates for the over 65s were78.33%, and at risk groups 62.95%. These were above national averages of 52.29% for over 65's influenza immunisations. Current data held by the practice demonstrated an overall 81% in the current cohort. Childhood immunisation rates for the vaccinations given to under twos were 100%.

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 published on 8 January 2015. The survey aggregated data collected from January to March 2014 and July to September 2014. There were 256 survey forms distributed for Westgate Surgery and 121 forms were returned.

Evidence we reviewed from a variety of sources showed patients were highly 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 was also well above average for its satisfaction scores on consultations with doctors and nurses, for example;

- Almost 98% said the GP was good at listening to them compared to the CCG average of 90.6% and national average of 88.6%.
- Over 94% said the GP gave them enough time compared to the CCG average of 87.4% and national average of 86.8%.
- Almost 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 96.1% and national average of 95.3%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 28 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. One comment was less positive. We also spoke with eight 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.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented 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. Additionally, in the GP patient survey 93.6% said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 86.9%.

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. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

People whose circumstances may make them vulnerable are able to access the practice without fear of stigma or prejudice as the practice has a clear equality and diversity policy and we observed staff treat people from these groups in a sensitive manner. People experiencing poor mental health were equally able to access services and were treated in a sensitive manner.

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, 93.9% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88.3% and national average of 86.3%.

Good

Are services caring?

Over eighty-nine percent said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83.8% and national average of 81.5%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. We received 28 patient feedback comment cards of these 27 were also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. We also noted that one member of staff was trained in British Sign Language (BSL), and was available to support communication with patients who used this language form.

We saw evidence of agreed care plans for older people, those with long term conditions and carers. These were reviewed annually or whenever there were any changes of conditions. We observed a bespoke children waiting area with toys and books that were clean and tidy. We saw evidence that the needs and the safety of children were considered by the practice when one patient suggested the practice should have a hot drinks machine in the waiting room this was respectfully declined to ensure the children in the surgery could be kept safe. Staff demonstrated to us that they understood both the Gillick competencies and Frazer guidelines.

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;

- 93.8% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87.7% and national average of 85.1%.
- 91.6% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90.8% and national average of 90.4%.

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 that 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. The practice offered annual health checks to all carers known to them.

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

We saw evidence that the social needs of older people were recognised. The practice actively promoted community groups and hosted a chair bound exercise class for the community for patients of their practice and other practices. The practice assesses those with long-term conditions and multi-morbidities for anxiety and depression as part of an annual review.

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 practice used CCG data and engagement with other agencies to understand the needs of the local population and worked with neighbourhood practices, secondary care, social services and the local council to provide integrated services to meet identified need. The practice had a healthy living worker deliver services in the practice including to advice on the reduction of alcohol and low level drug use. .

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 to better meet the needs of its population, for example one of the GP's was a non-executive Director to the CCG and actively offered the practice to pilot schemes to improve services such as the Neighbourhood Working Programme. This was an initiative for local practices to work with the third sector to ensure patients received the right social and health care to remain independent in their own homes. One of the partners was taking a lead role in the development of this scheme for the CCG.

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 improvements included markers to ensure confidentiality around the reception desk, a who's who board in the waiting area and the use of texts reminders for appointments.

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 and carers. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. Patients requiring language line translation were given longer appointments.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as most facilities were all on one level, a lift operated to allow access to the lower floor when necessary but the consulting rooms and treatment rooms were all located on the level. The consulting rooms were also accessible for patients with mobility difficulties and there was access to enabled toilets and baby changing facilities. We saw facilities for children were available in the patient toilet. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

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

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. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

The surgery was open from 08:00am to 18:00pm Monday to Friday. . Appointments were available from 08:00am to 11.30am and 13:30pm to 18:00 pm on weekdays. Extended hours were offered on certain days (patients had to ring the surgery to confirm the days)

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If

Good

Are services responsive to people's needs?

(for example, to feedback?)

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.

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.

The GP 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;

- 86% were satisfied with the practice's opening hours compared to the CCG average of 73.2% and national average of 75.7%.
- Almost ninety-six percent described their experience of making an appointment as good compared to the CCG average of 75.2% and national average of 73.8%.
- Over seventy percent said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 71.6% and national average of 65.2%.
- Almost ninety-nine percent said they could get through easily to the surgery by phone compared to the CCG average of 79.5% and national average of 74.4%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that 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. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking six weeks in advance. We saw that although sufficient appointment slots were available to meet anticipated need on each day receptionists could offer additional appointments and offer five minute appointments or telephone consultations for urgent patient issues.

For older people and people and those with long-term conditions home visits were available where needed and longer appointments when appropriate. There was an understanding that for working age people the practice needed to operate extended opening hours. This was accommodated by offering appointments from 7am on specific days. Online booking systems and an electronic prescription service were available and well used. The practice used text message reminder for appointments and test results, online or telephone consultations where appropriate. The practice used a number of ways to support people whose circumstances may make them vulnerable. These included working closely with the local health authority public health department, offering longer appointments for those that needed them and flexible services and appointments.

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 that information was available to help patients understand the complaints, including posters in the waiting area. Staff were aware of the need to support patients who wanted to complain in an unbiased way offering support when needed. The 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 three complaints received in the last 12 months and found that they were handled in line with the policy. The process was fair, timely and transparent. In all cases patients were offered face to face meetings to resolve the complaints, although not all were taken up by the patient.

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. We saw the minutes of the annual review of complaints and observed that there had been three complaints. All the complaints were verbal, and were logged and responded to appropriately. The lessons learnt were shared with the practice team and doctors reminded to consider slower dose reduction in some incidences, and all doctors were reminded to take care when choosing drugs from a pick list to ensure individual needs were listened to.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and business plan. We saw evidence the strategy and business plan were regularly reviewed by the practice and also saw the practice values were clearly displayed in the waiting areas and in the staff room. The practice vision and values was encapsulated in the phrase that the practice aims to treat well, cure often and care always.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them over time.

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 six of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All six 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 the GP was the lead for safeguarding. We spoke with nine members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. These included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with 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 also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Many audits were performed monthly to demonstrate progress against an action plan. 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 that 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 risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented. The practice monitored risks on a monthly basis to identify any areas that needed addressing.

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the induction policy and recruitment of locum GP's which were in place to support staff. Staff we spoke with knew where to find policies if required. The practice had a whistleblowing policy which was also available to all.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always takes the time to listen to all members of staff. All staff were 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 told us that the practice operated in a non-hierarchical way and all staff, including the partners, treated each other equally. Staff told us about a sense of belonging and a value of the care provided to the patients by all staff, clinical or otherwise.

Are services well-led?

Good

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

The three members of the PPG that we spoke to told us they felt valued the practice immensely and developments were always shared with them for opinion before implementing. They felt their views were listened to and that they could influence the running of the practice.

We saw from minutes that team meetings were held every week. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. We also noted that team time out was held regularly, known as Target. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Practice seeks and acts on feedback from its patients, the 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; members ranged from 18 to 80 years and were equally male and female. Some members had long term conditions; others had extensively used the service for relatives and were carers, while others were parents of young children. The PPG had carried out surveys and met routinely every six months, but also at other times if required. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and agreed changes from these surveys were available on the practice website. We spoke with three members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). They all felt able to influence developments in the practice but were extremely happy with the services the practice offered.

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice and notices in the waiting area encouraged patients to become involved in the PPG.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training around contraceptive implants 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 that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days known as Target sessions 10 times per year where guest speakers and trainers attended.

The practice was a GP training practice and both GP partners were GP trainers. The GP trainees were supported by the Harrogate GP Speciality Training Scheme. We were unable to speak to the trainees on the day of the inspection but spoke to both trainers and two salaried GP's who felt the present system was supportive to both the individual trainees and the practice.

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. The practice looked at all deaths in the previous quarter and if any lessons were learnt. Four of the deaths were expected and happed in hospital, the fifth was awaiting secondary care input but the practice had acted appropriately in all cases. Patients with a new cancer diagnosis were also discussed and the pathways compared to national standards. In all cases the processes with the practice met with national standards.