Waterside Practice

Quality Report

Waterside Practice
The Medical Centre
St.Brannocks Rd
Ilfracombe
Devon
EX34 8EG
Tel: 01271 863840
Website: www.watersidepractice.co.uk

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Waterside Practice was inspected on Tuesday 25 November 2014. This was a comprehensive inspection. Overrall the practice is rated as good.

Waterside Practice provides primary medical services to people living in the town of Ilfracombe. Waterside Practice is a medium sized practice caring for approximately 10,100 patients. The practice area covers approximately 60 square miles, with the majority of patients living in and around Ilfracombe, Combe Martin and a few larger villages. The area receives a considerable influx of tourists over the holiday season and this generates additional work for the practice.

The practice operates from two sites. The main site is Ilfracombe Medical Centre. This is purpose-built and is open five full days per week including some extended hours. The other site is a branch in Combe Martin and this is open five mornings and four afternoons each week. There are currently seven GP Partners, some part time, giving approximately 6 whole time equivalents. There is also a GP retainer for four sessions per week. The GP retainer scheme allows part time GPs to keep up to date with their clinical skills. A proportion of GP retainer salaries are paid for by the local clinical commissioning group.

Some areas which the practice supports have above average levels of deprivation. Ilfracombe Central is ranked the most deprived ward in Devon County. Life expectancy in Ilfracombe is below average at 77 years for the district, and is the lowest in Devon as a whole. There are high levels of substance and alcohol abuse, and significant levels of people with mental health problems.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

Our key findings were as follows:

Patient feedback about care and treatment was positive. The practice had a patient centred culture. Practice staff were well trained and experienced. Staff provided compassionate care to their patients. External stakeholders were positive about the practice.

Summary of findings

The practice was well organised, clean and tidy. The practice had well maintained facilities and was well equipped to treat patients. There were effective infection control procedures in place. Patients had easy access to appointments at the practice. Patients had a named GP which improved their continuity of care.

The practice had a clear leadership structure in place and was well led. Systems were in place to monitor quality of care and to identify risk and manage emergencies.

Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of the patient's capacity to make informed choices about care and treatment, and the promotion of good health.

Recruitment, pre-employment checks, induction and appraisal processes were in place. Staff had received appropriate training for their roles and additional training needs had been identified and planned.

Information about the practice provided evidence that the practice performed comparatively with all other practices within the clinical commissioning group (CCG) area.

Patients told us that they felt safe with the practice staff and confident in clinical decisions made. There were safeguarding procedures in place. Significant events, complaints and incidents were investigated. Improvements made following these events had been discussed and communicated with staff.

We saw several areas of outstanding practice including:

A urology specialist GP working at this practice had put forward guidance which had been adopted as best practice by the CCG.

In the event of receiving news of extreme adverse weather conditions in this area which abutted the hills of Exmoor, the practice had plans in place for a duty GP to stay overnight at the practice. This would enable a reduced service to carry on from the practice the following day despite deep snow.

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 safe. The practice was as safe as other similar practices. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses, for example in the recording significant events online system. The policy had been reviewed in October 2014.

There was a full staff meeting every quarter, with a GP in attendance, which included an open forum for discussion of any topics with staff.

All opportunities for learning from incidents were maximised to support improvement. Information about safety was valued and also used to promote learning and improvement. Risk management was comprehensive and recognised as the responsibility of all staff.

Risk assessments included the facilities, equipment, infection control, fire and patient safety. There were enough staff to keep people safe. This included seven GPs, six nurses, three health care assistants and an administration team.

Are services effective?

Good

The practice is rated as good for effective.

Discussions with practice staff and examination of the minutes of team meetings, audits and policies showed that systems were in place to ensure that all clinicians were up-to-date with national institute for care excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence that confirmed these guidelines were influencing and improving practice and outcomes for their patients.

We saw data that showed the practice was performing highly when compared to neighbouring practices in the clinical commissioning group (CCG). The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. For example, GPs at the practice regularly attended peer group forums and CCG meetings.

Specialists from other areas visited the practice on a monthly basis to examine the practice data and offer advice and up to date guidance. Two of the practice GPs were on the locality board. A urology specialist GP working at this practice had put forward guidance which had been adopted as best practice by the CCG.

Summary of findings

Are services caring?

Good

The practice is rated as good for caring.

Patient survey data showed 98% of patients rated the practice as very satisfactory for almost all aspects of care. Feedback from patients about their care and treatment was extremely positive. We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this.

Nurses were given the flexibility by the practice to set the times and duration of their own appointments according to individual patient's needs which demonstrated a patient centred culture

We found many positive examples to demonstrate how patients' choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings. The practice had an active Patient Participation Group (PPG) which included a virtual group online for patients unable to attend group meetings and forums in person. Staff felt supported by management at the practice and staff retention was high.

Are services responsive to people's needs?

Good

The practice is rated as requires improvement for responsive.

We found the practice had initiated positive service improvements for their patients. For example the provision of music in the waiting room and books in the children's play area as a result of patient feedback. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the PPG.

Complaints had been responded to appropriately and within a reasonable timescale. The practice had reviewed the needs of their local population and engaged with the NHS England Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. For example, the provision of a leg ulcer clinic by trained and experienced practice nurses.

Patients reported good access to the practice and a named GP or GP of their choice. They told us they could obtain urgent appointments the same day if required. The practice had modern facilities and was well equipped to respond to patients' needs.

Complaints from patients were audited on a quarterly basis by the practice manager. Any learning points were shared with all staff to enable the practice to make improvements by responding to patients' needs. For example, the letter invitation previously sent out

Summary of findings

to patients with long term conditions had been described as vague. This had been improved to include the date, contact name and contact details of the relevant member of staff at the practice to contact.

Some areas which the practice supports have above average levels of deprivation. Ilfracombe Central is ranked the most deprived ward in Devon County.

Life expectancy in Ilfracombe is well below average at 77 years for the district, and is the lowest in Devon as a whole. The town's life expectancy in Ilfracombe is also far lower than the national average. The UK national average life expectancy is 81.5 years.

Are services well-led?

Good

The practice is rated as good for well-led.

The leadership team at the practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was set out in the practice leaflet. The practice had a simple leadership structure which staff found easy to understand. GPs had clear lead roles, for example in safeguarding and in child protection.

All staff reported their morale was high. Staff retention was high. Appropriate human resources policies were in place to support staff and also address performance and capability when required. High standards were promoted and owned by all practice staff with evidence of team working across all roles. The practice has a strong ethos of supporting staff development. A half day each quarter was spent on training and development of areas of use to the practice population and of interest to staff. The practice had supported one phlebotomist to become a health care assistant and obtain a higher level national vocational qualification.

Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients, which included using new technology, and had a very active patient participation group (PPG).

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 population group of Older Patients over 75.

All patients in this population group had a named GP who was responsible for their health. In June 2014, the practice wrote to all their patients who were over 75 to remind them who their GP was, and to set out what their GP could do to help them. A health check was available to any patient over 75 who requested one.

The practice maintained regular and timely communication between the GPs, the Practice Nursing team and the Community Nurses. The latter were based in the practice and had access to patient clinical records. Both nursing teams were crucial to provision of care to this group of patients and there were excellent working relationships between the teams.

The practice was participating in the Unplanned Admissions Enhanced Service, and as part of this had created a list of their 2% most vulnerable patients. Most of these were aged over 75. Each of these patients had had a care plan agreed with them which was designed to help them avoid emergency admission to hospital or visits to A&E. Where appropriate, this involved other healthcare professionals. The patients on this register were reviewed at least quarterly, and after any attendance at A&E or admission.

The practice maintained an End of Life register which included any patients who were thought to be within the last few months of their lives. The GPs in the practice met with members of the Primary Healthcare team (District Nurses, Community Matron, Hospice Specialist Nurse) every two weeks to review all patients on the End of Life register and any patients on the vulnerable register with particular issues. This ensured joined-up working between the professional groups.

The practice offered seasonal flu vaccinations to patients in this population group including weekend flu

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions.

The practice has a significant number of patients with long term conditions with above the England average prevalence for diabetes,

asthma, chronic obstructive pulmonary disease (COPD), and cardio vascular disease (CVD). The practice has developed a system of care for patients in this population group that provides them with as much support as possible with the practice's available resources.

All patients in this population group are called to the practice as a minimum once per year for a full review of their health. This is normally done in the month of their birth, and wherever possible, the practice tries to avoid calling patients for more than one review by combining review appointments. This can be done for diabetes and CVD, and sometimes for asthma, but not normally for COPD. This is because COPD appointments are more specialist and the nurses do not all have the necessary skills to do these reviews. Some patients will have more frequent reviews, as determined by their condition and how well they are.

The practice encourages patients to participate fully in managing their own long term conditions, with things like self-management plans for patients with COPD and asthma. The practice ensures COPD patients have rescue medicines at home which they can take at the first signs of infection and possibly help to avoid admission to hospital. Where relevant, the practice offers patients with COPD referral to pulmonary rehabilitation and also support from a respiratory outreach service.

The practice nurse team leader is a specialist diabetic nurse, with a high level of skill that enables her to manage quite complex patients. She is specifically trained in this area, and runs courses for newly diagnosed diabetics to help them to understand their disease and how they manage themselves to reduce the impact of it in the future. She also provides home visits for diabetic patients who are housebound to ensure they get the same level of care as other more mobile patients.

Quality Outcomes Framework (QOF) statistics show the practice performs well in supporting this population group. The QOF is a voluntary system which provides primary medical services with financial incentives to achieve health related objectives. In the last twelve months, QOF showed that the practice had achieved the following percentage scores for completing reviews of patients with long term conditions; asthma 84.3%, COPD 92.8%, diabetes 96.3%, dementia 90.6%. These were above average for the CCG and above the national average.

Families, children and young people

Good

The practice is rated as good for the population group families, children and young people.

Summary of findings

The practice offers a range of services for this group of patients, and tries wherever possible to ensure that it offers access to these services in a way which suits their lives. For example, local midwives are based in the practice and are able to offer expectant mothers their ante-natal appointments in the practice, which is familiar for them. The midwives use the practice's clinical system for recording notes so there is joined-up working with others in the practice.

For mothers with new babies, the practice offers a single appointment with their own GP for their post-natal and also their baby's first development check. Providing the baby is well, they can then go on and have their first immunisations straight afterwards, so that mother and baby only have to attend the practice once for all these things to be done.

The practice has a baby-changing room and offers mothers the opportunity to breast feed their babies in a private room if required.

Until a few years ago, the practice had generally lower than average scores for childhood immunisations, in part related to the socio-economic situation in the local area. The practice has introduced various new systems and processes to improve this in order to successfully achieve targets for both under two year olds and pre-school immunisations.

The practice is currently offering influenza vaccinations to children aged 2 - 4 years as part of the national programme. The practice made this service family-friendly by launching their campaign during the half term holiday, then continuing it by offering appointments after school has finished for the day.

The practice offers a range of women's health services, including the fitting and removal of coils and contraceptive implants, other contraceptive services and smear tests.

The practice offers a text reminder service (provided the patient consents) which will send a reminder the day before any booked appointment. The practice has found this is a valuable way to engage with younger patients in this population group who live busy lives with a focus on mobile phones and similar technology.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working age people (including those recently retired and students).

Examples of how the practice tailors its services to suit this group of patients are as follows. The practice is open from 8.30am to 6.00pm

Summary of findings

every day and on at least one day per week, several GPs offer appointments until 7.30pm. Patients who work during the day are thus able to make appointments at times that do not disrupt their working lives.

The practice always offers appointments for influenza vaccinations on Saturdays to try to ensure those patients at higher risk of the effects of influenza and who are working are able to attend.

The practice provides an online appointment booking service, together with the ability to order repeat prescriptions. Patients can also fax their repeat prescription requests to the practice.

The practice nursing team includes five team members who are trained as Stop Smoking advisors. They are all flexible about offering appointments to suit working patients in this population group.

Practice participation in the NHS Health Checks programme enables the practice to encourage some patients who may not normally attend the practice to engage with the practice, and potentially identify those at risk of developing long term cardiovascular health problems.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable.

The practice tailors its services to meet the needs of this population group. For example, the practice offers annual health checks to patients with learning disabilities (LD), and works with them, and their carers if appropriate, to agree easy to understand health plans for the following year. The practice also liaises with the LD specialist nursing team as appropriate.

The practice maintains a vulnerable adults register, and this is reviewed regularly with members of the primary health care team. This is flagged on their records.

The safeguarding of children is a key responsibility for everyone in the practice, and the practice has a system in place to ensure that at risk children are easily identifiable. The practice has a GP Safeguarding Lead and an administrator with responsibility for ensuring that records are kept up to date and that all the necessary reports and interventions are made. The GPs meet with the public health nurses and the relevant social workers quarterly to review the children on the register and to share issues.

Summary of findings

Ilfracombe has an extremely low level of homelessness, with the practice on average only having one homeless patient at any one time. The practice provides services to patients who do not have a fixed abode.

Staff told us about how the practice worked with local agencies to support patients with drug or alcohol abuse problems. The local CCG commissions drug and alcohol services from RISE (Recovery and Integration Service) and this includes psychological support for patients. The practice worked closely with RISE to respond to patient's needs. All the practice GPs had received up to date training from RISE in October 2014 to assist them in working together to support these vulnerable patients.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia).

The practice has effective links with the Depression and Anxiety Service in North Devon and its patients can self-refer (which is encouraged) or be referred by their named GP.

The practice has frequent liaison with Devon Partnership Trust which is the local mental health NHS Trust and has a team who are based in Ilfracombe. This team offers support and interventions to patients with mental health needs, and there is an appropriate level of information sharing between them and the practice.

The practice has the services of a talking therapies counsellor who offers appointments to patients in the practice one day per week. The practice has found that this system takes away the stigma of patients having to go to a mental health team location for help.

The practice has various ways of helping patients who are distressed and anxious when they need to attend the practice. For example, they can be offered a side room to wait in before their appointment. GPs will also offer double appointments to patients if they are aware that they have specific needs to spend time with them.

GPs have access to support services for patients with alcohol and drug misuse issues through a support group. In addition, three practice GPs have just agreed to take on the shared care of prescribing of methadone to patients and will start this after appropriate training. This facility enables patients to access this service at the practice rather than having to travel.

Summary of findings

What people who use the service say

We spoke with ten patients during our inspection. We also spoke with representatives of the patient representation group. The practice had provided patients with information about the Care Quality Commission (CQC) prior to the inspection. A CQC comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected eight comment cards which contained positive comments.

These comment cards recorded that patients thought staff at the practice provided a very caring service. Patients reported that the practice was clean and well organised. Patients said that they felt safe and expressed confidence in all of the staff at the practice. All of the patients who made comments were satisfied with the care and treatment they received.

Patients told us about their positive experiences of care and support they consistently received at the practice. Patients said they were very pleased with the staff at the practice satisfied and that they received effective and kind treatment. Patients told us that the GPs were caring and professional.

Patients expressed satisfaction with the appointments system. Patients told us that they could almost always get an appointment at a time and on a day convenient to them. Patients told us that the practice responded promptly and effectively to feedback and always listened to patient views.

Patients knew how to contact services out of hours and said information at the practice was good. Patients knew how to make a complaint. Patients told us they had no concerns or complaints but knew how to complain should they wish to do so.

Patients were pleased with the facilities at the practice and commented on the building always being clean and well organised. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided. Patients found it easy to get repeat prescriptions and said they thought the information provided and the practice website was useful.

Outstanding practice

We saw several areas of outstanding practice including:

A urology specialist GP working at this practice had put forward guidance which had been adopted as best practice by the CCG.

In the event of receiving news of extreme adverse weather conditions in this area which abutted the hills of Exmoor, the practice had plans in place for a duty GP to stay overnight at the practice. This would enable a reduced service to carry on from the practice the following day despite deep snow.

Waterside Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team also included a GP specialist advisor, a practice nurse specialist adviser, a practice manager specialist advisor and an expert by experience.

Background to Waterside Practice

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

Waterside Practice was inspected on Tuesday 25 November 2014. This was a comprehensive inspection.

Waterside Practice provides primary medical services to people living in the town of Ilfracombe. Waterside Practice is a medium sized practice caring for approximately 10,100 patients. The practice area covers approximately 60 square miles, with the majority of patients living in and around Ilfracombe, Combe Martin and a few larger villages. The area receives a considerable influx of tourists over the holiday season and this generates additional work for the practice.

The practice operates from two sites. The main site is Ilfracombe Medical Centre. This is purpose-built and is open five full days per week including some extended hours. The other site is a branch in Combe Martin and this is open five mornings and four afternoons each week. There are currently seven GP Partners, some part time, giving approximately 6 whole time equivalents. There is also have a GP retainer for four sessions per week.

Some areas which the practice supports suffer from deprivation. Ilfracombe Central is ranked the most deprived ward in Devon County. Life expectancy in Ilfracombe is well below average for the district and is the lowest in Devon as a whole. There are high levels of substance and alcohol abuse, and significant levels of people with mental health problems.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

The practice has a primary medical services contract with the NHS.

Waterside Practice comprises two locations. The main branch is situated at Ilfracombe Medical Centre, St Brannocks Road, Ilfracombe. We visited this main branch location for this inspection. The second branch is located at Combe Martin Health Centre, Castle Street, Combe Martin. We did not visit the Combe Martin branch as part of this inspection.

Waterside Practice is open Monday to Friday 8.30 am until 6.00 pm. In addition the practice offers early opening before 8.00am and late appointments after 6.30pm on certain days each week. These are pre bookable appointments which patients access via the practice reception team.

Detailed findings

Outside of these hours a service is provided by another health care provider by patients dialling the national 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before conducting our announced inspection of this practice, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, the local clinical commissioning group and local voluntary organisations.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

We carried out our announced visit on Tuesday 25 November 2014. We spoke with ten patients, four patient representative group members at the practice during our inspection and collected eight patient responses from our comments box which had been displayed in the waiting room.

We obtained information from and spoke with ten staff at the practice including the practice manager, four GPs, clerical staff, nurses and health care assistants. We observed how the practice was run and looked at the facilities and the information available to patients.

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. A national patient safety alert regarding a medicine called naloxone used to counter opiates had been recently received and transmitted to all staff at the practice by the practice manager. The practice manager had checked with all GPs at the practice whether this medicine was currently in use with any of their patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last four years. The practice had incident reports going back over the last five years. This showed the practice had managed these consistently over time and so could evidence 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. Records were kept of significant events that had occurred during the last five years and these were made available to us. A slot for significant events was on the practice meeting agenda and a dedicated meeting occurred monthly to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. For example, a young mother had attended the practice for a check on her new baby. The baby had held its breath during the visit. Staff at the practice discovered that there was no child sized oxygen mask in the emergency kit at the practice. This had been remedied. Learning points from this incident had been shared with all staff, such as regular checking and replenishment of the emergency kit.

Incident forms were available on the practice intranet. Once completed these were sent to the practice manager who showed us the system she used to oversee these were managed and monitored. We tracked two incidents and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, guidance had been discussed with reception staff following the incident outlined in the paragraph above.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had a lead GP for safeguarding and a lead GP for child protection. The practice also had a lead deputy practice manager for safeguarding. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a vulnerable adults register in place. The criteria for entry on this register included patients with learning disabilities, dementia, living alone and other risk related factors. There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example children subject to child protection plans were discussed with the health visitors and subject to regular case conferences to ensure their safety and wellbeing.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible online and on hard copy.

A chaperone policy was in place and displayed on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants. Staff understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. Staff had received a criminal records bureau check via the Disclosure Barring Service (DBS).

Individual patient records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence that annual audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Good

Are services safe?

Medicines Management

All the medicines we checked were within their expiry dates. All medicines were checked monthly and a checklist documented this. Processes were in place to check medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of by an offsite pharmacist as required and in line with guidance.

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

There was a secure fridge used for cold storage of vaccinations. The temperature of this unit was monitored and recorded on a checklist. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice.

We checked the completed prescription forms held at reception for patients to collect. We found three prescription forms dated September 2014. The practice manager told us they would amend their checking schedule of these forms from once every two months to once every month.

Cleanliness & Infection Control

The practice was clean and tidy. 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.

All staff received induction training about infection control specific to their role and annual updates. An annual infection control audit had been carried every year for the past two years. We looked at the 2014 audit and saw that improvements identified for action were completed on time, for example the use and provision of personal protective equipment (PPE) such as gloves and aprons. Practice meeting minutes showed the findings of the audits were discussed. The infection control policy had been reviewed within the last 12 months.

There was also a policy for needle stick injury and guidance on display to support staff who experienced this. Hand washing guidance was on display by all sinks. Hand washing facilities included liquid soap and paper towels. Bare below the elbow checks on staff had been completed and recorded to ensure staff complied with the hand washing policy and training.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). A legionella audit had been conducted which was repeated annually to review any changes.

Equipment

Staff at the practice told us they had enough modern equipment to enable them to carry out diagnostic examinations, assessments and treatments. Evidence showed 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 on annual basis and displayed stickers indicating this.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal record bureau checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The practice manager told us they checked clinical staff's professional registrations on an annual basis to ensure these were maintained.

The GPs at the practice had a range of specialist skills. 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 there were enough staff on duty.

Staff told us there were enough staff to maintain the efficient running of the practice and there were always

Good

Are services safe?

enough staff on duty to ensure patients were kept safe. The practice manager had completed a staff needs analysis to ensure there were enough staff on duty to satisfy patient needs especially at peak times.

Monitoring Safety & Responding to Risk

Risk was managed and monitored on annual schedules of risk assessments which were carried out through the year. These included risk assessments on fire alarms, emergency equipment, lifts, work stations and the equipment at the practice.

Visitors to the practice were required to sign in on arrival. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there were identified health and safety representatives.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. For example, the practice had a business continuity plan in place which was updated on annual basis. This set out how the practice could carry on operationally if one of their two sites was put out of action through snow, flooding, fire or other emergency.

In the event of receiving news of extreme adverse weather conditions in this area which abutted the hills of Exmoor, the practice had plans in place for a duty GP to stay overnight at the practice. This would enable a reduced service to carry on from the practice the following day despite deep snow.

We saw records showing all staff had received training in administering first aid and basic life support to both adult and child patients in January 2014. Emergency equipment was available including access to oxygen and an automated external defibrillator (AED - used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. During our inspection we found one oxygen cylinder with no label on to indicate whether it had been serviced. However, we did find another oxygen cylinder which had a label with the relevant information on to confirm it had been serviced and was safe to use.

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

An annual fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff had received fire training in August 2014 and that annual fire drills were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs and nursing staff clearly outlined 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 and from local commissioners.

The ten patients we spoke with were pleased with the treatment and advice they received. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines.

GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which enabled effective patient care. Staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, nurses we spoke with told us this enabled them to specialise in looking after patients with asthma. Patients told us that asthma and COPD clinics were provided on an ongoing basis and that they had found them effective.

National data and practice computer systems showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The GPs used national standards for the referral of suspected cancers within two weeks. We saw systems used by administration staff to show how routine and urgent referrals were made.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making. There were four female and three male GPs at the practice, with a range of different ages.

Management, monitoring and improving outcomes for people

The practice monitored its service delivery to patients via the Quality Outcomes Framework (QOF). QOF is a voluntary system which provides practices in England with financial incentives to achieve health targets. QOF data showed us that the practice was exemplary in its QOF completion and compared well with other practices in the CCG and nationally.

The practice used QOF to measure the percentage of patients with diabetes who had received an annual health check, which was very high at 96%. Of the patients with dementia, 90.6% had received an annual review. 92.8% of patients with COPD had been reviewed. This showed that the practice monitored outcomes for its patients and scored highly in comparison with other practices.

The practice showed us four clinical audits that had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit.

Examples of clinical audits included audits on medicines, to see whether their use complied with NICE guidelines. The audit found that in each case the guidelines had been complied with. The GPs told us clinical audits were often linked to medicines management in order to improve outcomes for patients.

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 upon 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.

Effective staffing

The range of staff at the practice included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with annual safeguarding and infection control. However, there was no system in place to provide a catch up session if staff missed an infection control training session, for example if they were on annual leave. This was identified by practice manager who was planning to introduce improvements to the training programme.

There was a broad skills mix among the GPs. They 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

Good

Are services effective?

(for example, treatment is effective)

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 received 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 training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, those with extended roles such as the provision of a regular diabetes clinic were able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X-ray results, letters from the local hospital (including discharge summaries), and out of hour's providers were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing 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.

GPs held follow up reviews with patients recently discharged from hospital within two weeks of their date of discharge.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patents e.g. fortnightly primary health care meetings, significant event meetings on a monthly basis. These meetings were attended by community mental health nurses, district nurses, social services, palliative care nurses and decisions about care planning were documented in a shared care record. Staff said this system worked well.

Information Sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. The practice shared treatment escalation plans (TEP) with the out of hours GP service and had the facility to send and receive special messages with individual patient information.

For emergency patients, there was a practice policy of providing a printed copy of a summary record for the patient to take with them to A&E. This document could also be faxed from a secure fax to the hospital. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E.

Consent to care and treatment

We found that staff had been trained within the last 12 months on the Mental Capacity Act 2005 and understood their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. The practice kept a register of all patients with learning disabilities. 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. For example, all consent forms at the practice had been scanned into the electronic record system.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

The practice had not had an instance where restraint had been required in the last 3 years but staff were aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

The practice had contact with the Public Health team from the Local Authority and the CCG to discuss the implications and share information about the needs of the practice

Good

Are services effective?

(for example, treatment is effective)

population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity. For example, the practice smoking cessation service had increased their staffing numbers to five trained advisors as a result of feedback from the above.

New patients at the practice were invited to complete a comprehensive questionnaire about their health and medical history. This data was used to assess their needs and whether an initial consultation with a GP or nurse was required.

The practice has offered NHS Health Checks to patients aged 40-75 since October 2013. The practice health care assistants completed these. A GP showed us how patients who had risk factors for disease identified at the health check were followed-up within 10 days and were scheduled for further investigations.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all of these were offered an annual physical health check.

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. There was a clear policy for following up non-attenders by the practice nursing team. The practice had held two Saturday clinics for influenza vaccinations and successfully administered the vaccine to 1,200 patients.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The practice regularly sought and reviewed patient feedback on this area. We looked at patient experience survey results completed over the last twelve months. This included information from the national patient survey, there had been 128 respondents. Of these, 96% said staff had treated them with respect and that they had confidence and trust in the staff.

The PPG had also completed a patient survey and had obtained feedback from 399 respondents in the financial year 2013-2014. The evidence from this source showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the survey showed 97% of patients were pleased in the manner in which they were treated by staff.

Patients completed CQC comment cards to provide us with feedback on the practice. We received eight completed cards and all of these were positive about the service experienced. Patients said they felt the practice provided a friendly and welcoming service. They said staff treated them with respect and empathy. We also spoke with ten 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 that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains with expiry dates displayed 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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the surveys showed 93% of practice respondents said the GP involved them in care decisions and they felt the GP was good at explaining treatment and results.

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

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

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 95% of respondents to the patient survey said when it had been needed they were helped to access support services to help them manage their treatment and care. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information.

Notices in the patient waiting room, on the information screen and patient website also told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

Good

Are services caring?

Staff told us that if families had suffered bereavement, their usual GP provided support. There were posters and leaflets offering advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was rated as good for meeting patient's needs. The local area is subject to a level of deprivation, together with substance misuse and alcohol abuse. The practice has responded to this need.

For example, staff told us about how the practice worked with local agencies to support patients with drug or alcohol abuse problems. The local CCG commissions drug and alcohol services from RISE (Recovery and Integration Service) and this includes psychological support for patients. The practice worked closely with RISE to respond to patient's needs. All the practice GPs had received up to date training from RISE in October 2014 to assist them in working together to support these vulnerable patients.

Two GPs at the practice had recently completed the RCGP Management of Drug Abuse level one to enable them to share methadone prescribing with RISE.

The needs of the practice population were varied and systems were in place to attempt to address identified needs. The practice used the chadsvasc IT tool which is a risk tool to help GPs detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

The practice used an IT tool to identify patients at risk of dementia. Patients falling into this category would be seen by their GP and receive support including a referral to a memory clinic.

GPs met every morning to discuss patients' needs at the practice and how to meet these needs. The GPs also met fortnightly to discuss operational requirements to make any changes to meet patient needs.

There had been low turnover of staff during the last five years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for patients who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to a nursing home and to ten local care homes, by named GPs to those homes which had indicated the need for a visit.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, at a time when there are ever-increasing demands on healthcare services, and limited financial resources, the PPG felt that it would be appropriate for the practice to publish self-help guidance to assist patients. These would include patients caring for their own health, dealing with minor ailments, advice about diet and lifestyle, and choosing the appropriate healthcare professionals for a particular problem.

The practice had introduced improvements to training for reception team members. This included participation in a project related to improving access to the practice for patients with urgent health problems. The practice had also started a review of practice policies on telephone access.

Tackle inequity and promote equality

The practice provided equality and diversity training and staff confirmed that they had completed the equality and diversity training within the last 12 months.

The local area experiences a large influx of holiday makers of a range of different nationalities during the summer. There are also a number of English language schools for foreign students in the area. The practice had access to online and telephone translation services and had two GPs who spoke languages other than English. The PPG survey results stated that 7% of patients for whom ethnicity is recorded at the practice were of ethnic origin other than White British.

The premises and services had been adapted to meet the needs of people with disabilities. For example, automatic door openers were in place to help patients in wheelchairs, with prams or those with mobility issues. There was a designated accessible toilet which had been fitted with grab rails and an alarm cord.

The practice was situated on one level. The practice had open spaces in the waiting room which provided turning circles for patients with mobility scooters. Corridors and doors were wide making the practice easier and helped to maintain patients' independence.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that the waiting area was large enough to accommodate patients with prams and allowed for easy access to the treatment and consultation rooms. There were quiet areas for breast feeding mothers and baby changing facilities available.

Access to the service

The patient facing areas of the practice were situated entirely on the ground floor of the building which allowed ease of access. Appointments were available from 8.30 am to 6.00 pm on weekdays. Early opening was available before 8.00am and after 6.30pm on certain days each week. The practice had a facility for urgent appointments to be made.

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 in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Written and verbal feedback from patients indicated that they were satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system, including posters and leaflets in the waiting area together with a visual display unit which included how to make a complaint should patients wish to do so. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at two complaints received in the last twelve months and found these had been satisfactorily handled and dealt with within a reasonable timescale. The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon. This included discussion at team meetings to share learning points.

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 vision to deliver high quality care and promote positive outcomes for patients. We found details of the vision and practice values in the practice leaflet. The practice vision and values included the following: to take pride in providing a personal, traditional type of family medicine to improve the general health of the population and reduce preventable disease. In view of this, a strong emphasis was placed on health promotion and education. However, it should be noted that this vision was not displayed on a poster in the patient waiting room.

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

The practice did not have a five year business plan in place. The practice manager told us this was because the practice had, by necessity, adopted a responsive approach in the current period of constant change.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at nine of these policies and procedures and most staff had completed a cover sheet to confirm they had read the policy and when. All nine policies and procedures we looked at had been reviewed annually and were up to date. The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing above average compared with other practices across England. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had completed a number of clinical audits, for example ten audits had been completed within the last twelve months on a wide range of medicine usage. Actions arising from these audits had been completed and a new audit had taken place or was planned to take place. This showed that the complete audit cycle was in place.

Every week the practice partner GPs and the practice manager held a clinical governance meeting. We saw minutes that effective good governance was in place. For example, discussions about operational requirements and planning had taken place.

Leadership, openness and transparency

The practice had a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and a senior partner GP was the lead for safeguarding. We spoke with ten members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued and knew who to go to in the practice with any concerns.

The practice GPs held daily meetings where complaints, significant events and incidents were discussed along with day to day events. We were told that there was a plan to introduce a more formal quarterly meeting where all staff could attend. The practice held two team events every year which included a Christmas and a summer social event to maintain the high level of team morale enjoyed at the practice.

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

Practice seeks and acts on feedback from users, public and staff

Evidence from patient surveys including a patient participation group survey within the last twelve months showed that the practice took feedback seriously and acted upon it.

The patient participation group survey had gathered feedback from 399 respondents. This showed patients wanted a review of practice policies on telephone access, text messaging system and an up to date practice website and a review of waiting room music. This feedback had been implemented by the practice.

The practice manager showed us improvements which had been made such as collaborative working with the neighbouring practice in communications, shared staffing and a new simpler management structure.

Are services well-led?

Good

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

The practice had gathered feedback from staff through face to face discussions, appraisals and through any staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Staff showed us the practice whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

The practice was a GP training practice and a staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four 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 where guest speakers and trainers attended.

The practice had completed reviews of significant events and other incidents. The GPs were in the process of introducing more formal ways of sharing action and learning from these events with the wider staff group to ensure the practice improved outcomes for patients.

The practice has a strong ethos of supporting staff learning and development. A half day each quarter was spent on training and development of areas of use to the practice population and of interest to staff. The practice had supported one phlebotomist to become a health care assistant and obtain a higher level national vocational qualification.