Seaford Medical Practice

Quality Report

Seaford Health Centre
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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 of Seaford Medical Practice on 29 April 2015. We visited the practice location at Seaford Health Centre, Dane Road, Seaford, BN25 1DH.

Overall the practice is rated as good. Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for 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 and people experiencing poor mental health (including people with dementia).

The inspection team spoke with staff and patients and reviewed policies and procedures. The practice understood the needs of the local population and engaged effectively with other services. The practice was committed to providing high quality patient care and patients told us they felt the practice was caring and responsive to their needs.

Our key findings were as follows:

- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect.
- The practice understood the needs of the local population and planned services to meet those needs.
- The practice engaged effectively with other services to ensure continuity of care for patients.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Staff were very well supported and felt empowered within their roles.
- Staff described a culture of openness, transparency and continuous improvement.
- Leadership and management of the practice ensured high levels of attention to detail which contributed to the smooth running of the practice

There were areas of practice where the provider needs to make improvements.

The provider should:

Summary of findings

- Ensure that the practice chaperone service is clearly advertised to patients within the waiting area and consulting and treatment rooms.
- Ensure care plans clearly indicate the date when they are due for review.

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. Information about safety was recorded, monitored, appropriately reviewed and addressed. Staff had a good understanding of procedures relating to the safeguarding of children and vulnerable adults and staff had received training in adult and child safeguarding at a level appropriate to their role. Risks to patients were assessed and generally well managed. The practice had assessed the risks associated with potential exposure to legionella bacteria. There were enough staff to keep patients safe.

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Information to help patients understand the services available was easy to understand. We saw that staff treated patients with kindness and respect, and maintained confidentiality. The practice promoted local support groups so that patients could access additional support if required. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its' local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified. Urgent appointments were available on the same day. The practice

Summary of findings

provided a system of GP led triage for patients who requested an urgent appointment. The practice was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt well supported by management. Staff told us they felt valued and empowered to fulfil their roles to a high standard. High levels of attention to detail were paid to service planning and the management and support of staff. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. High levels of attention to detail were paid to service planning and the management and support of staff. Nurse training, development and mentoring programmes were well documented and monitored. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients. 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 older patients in its population. The practice ensured early referral to services for memory assessment. It was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs. All patients over the age of 75 years had a named GP. Flu vaccinations and health checks were available to older patients. The practice had recently participated in a specific project to improve patient care and access to primary care for patients living in local nursing and residential homes. The practice held regular meetings with the neighbourhood support team to review the care and support of older patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. GPs and nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Care plans were in place to minimise the risk of unplanned hospital admissions. Longer appointments and home visits were available when needed. All of these patients had a named GP and a structured regular 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. The practice worked closely with the neighbourhood support team, in the management of patients with long term conditions.

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. Practice staff had received training in the safeguarding of children relevant to their role. All staff were aware of child safeguarding procedures and how to respond if they suspected abuse. Immunisation rates were relatively high for all standard childhood immunisations. The practice provided weekly immunisation clinics. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours

and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. The practice worked closely with a local specialist school to provide care to young patients with a range of behavioural, emotional and social support needs.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered extended hours on one evening each week and on Saturday mornings to meet the needs of people who worked during the day. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. NHS health checks were available to all patients aged from 45-74 years.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability. Longer appointments were available to patients where needed, for example when a carer was required to attend with a patient. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had identified those vulnerable patients requiring support to minimise the risk of accident and emergency attendance and unplanned hospital admissions. Care planning was in place to support those patients. Patients receiving palliative care were supported by regular multidisciplinary team reviews of their care needs. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The practice worked closely with a local specialist school to provide care to young patients with a range of behavioural, emotional and social support needs.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had a named GP and received an

annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had identified a lead GP for the management of patients with dementia. It carried out care planning for patients with poor mental health such as dementia and learning disabilities. The practice undertook dementia screening of patients and ensured early referral to memory assessment services. The practice had provided information to patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with mental health needs and dementia. Longer appointments were available to patients if required.

Summary of findings

What people who use the service say

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received seven comment cards all of which contained positive comments about the practice. We also spoke with four patients on the day of the inspection.

The comments we reviewed were all positive about the service experienced. Patients said they felt the practice offered a caring service and staff were efficient, helpful and took the time to listen to them. They said staff treated them with dignity and respect. Two of the comment cards described the excellent care received in managing multiple health problems. Patients told us they were able to access the practice by telephone and they were usually able to obtain an appointment at a time which met their needs. Patients we spoke with on the day of inspection told us that all staff were helpful, caring and professional. They told us they felt listened to and well supported.

We reviewed recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were very satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 92.8% of patients rated their overall experience of the practice as good. We noted that 82.6% of patients had responded that the nurse was good at treating them with care and concern. The survey also found that 85.88% of patients said the last GP they saw was good at involving them in decisions about their care, compared with a national average of 81%.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that the practice chaperone service is clearly advertised to patients within the waiting area and consulting and treatment rooms.
- Ensure care plans clearly indicate the date when they are due for review.

Seaford Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Seaford Medical Practice

Seaford Medical Practice provides general medical services to approximately 17,700 registered patients. The practice delivers services to a higher number of patients who are aged 65 years and over, when compared with the national average. Care is provided to patients living in residential and nursing home facilities and one local hospice. Data available to the Care Quality Commission (CQC) shows the number of registered patients suffering income deprivation is lower than the national average.

Care and treatment is delivered by eleven GP partners and one salaried GP. Six of the GPs are female and six are male. The practice manager is a business partner within the practice. The practice employs a team of five practice nurses, five healthcare assistants and one phlebotomist. GPs and nurses are supported by the practice manager, a team of administration and services managers and a team of reception and administration staff.

The practice is a GP training practice and supports new registrar doctors in training.

The practice is open from 8.00am to 6.00pm on weekdays. Extended hours consultations are available one evening per week from 6:30pm until 8:30pm and on Saturday mornings from 8.30am to 11.05am. The practice operates a flexible appointment system to ensure all patients who needed to be seen the same day are accommodated.

Services are provided from:

Seaford Health Centre, Dane Road, Seaford, BN25 1DH.

The practice has opted out of providing out of hours services to its own patients and uses the services of a local out of hours service.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the NHS Eastbourne, Hailsham and Seaford clinical commissioning group (CCG). We carried out an announced visit on 29 April 2015. During our visit we spoke with a range of staff, including GPs, practice nurses and administration staff.

Detailed findings

We observed staff and patient interaction and spoke with four patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed seven comment cards completed by patients, who shared their views and experiences of the service in the two weeks prior to our visit.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice 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 to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. 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 database system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred and we were able to review these. Significant events were discussed at weekly partners' meetings, clinical governance meetings and practice team meetings. We saw evidence of those meetings. We saw that records of incidents were completed in a comprehensive and timely manner and that there was appropriate action taken as a result. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nurses, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

GP and nurses were able to describe their involvement in significant events and incidents which had taken place and the learning involved. For example, the practice had recently reviewed their protocol for the management of patients with suspected deep vein thrombosis in response to one incident. Current best practice guidance had been circulated within the practice and included within GP induction information.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for.

They also told us alerts were discussed at regular partners' and clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young patients and adults. A designated GP partner was the practice lead for safeguarding children and vulnerable adults. Safeguarding policies and procedures were consistent with local authority guidelines and included local authority reporting processes and contact details.

The GP partners had undertaken training appropriate to their role. All staff had received training in the safeguarding of children and vulnerable adults at a level appropriate to their roles. Staff could demonstrate they had the necessary knowledge to enable them to identify concerns. All of the staff we spoke with knew who the practice safeguarding lead was and who to speak to if they had a safeguarding concern. We saw that safeguarding flow charts and contact details for local authority safeguarding teams were easily accessible within the practice.

Staff described the open culture within the practice whereby they were encouraged and supported to share information within the team and to report their concerns. Information on safeguarding and domestic abuse was displayed in the patient waiting room and other information areas.

There was a system to highlight vulnerable patients on the practice computer system and patient electronic records. This included information to make staff aware of specific actions to take if the patient contacted the practice or any relevant issues when patients attended appointments. For example, children subject to child protection plans.

The practice had a chaperone policy. A chaperone is a person who can offer support to a patient who may require an intimate examination. The practice policy set out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. We were told that only nurses and healthcare assistants were required to undertake chaperone duties. Those staff had been subject to a criminal records check via the Disclosure and Barring Service. We found that the chaperone service was not clearly advertised to patients

within the practice. The service was displayed on the electronic display screen in the reception and waiting area, however details of the chaperone service appeared only intermittently and patients could easily have missed the information. We noted that the practice did provide information about the chaperone service on their website and within the practice information leaflet.

Patients' individual 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 clinical summaries, scanned copies of letters and test results from hospitals.

GPs were appropriately using the required codes on their electronic system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. GPs were aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services. The practice worked closely with the health visitor with whom they met on a regular basis to ensure a timely exchange of information.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. There was a clear process for ensuring medicines were kept at the required temperatures. We reviewed records which confirmed this. The correct process was understood and followed by the practice staff and they were aware of the action to take in the event of a potential power failure.

The practice had processes to check medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations.

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. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw that nurses had received appropriate training to administer vaccines.

The practice implemented a comprehensive protocol for repeat prescribing which was in line with national guidance. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. Reviews were undertaken for patients on repeat medicines. 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 and kept securely at all times.

The practice had identified a lead GP for medicines management. The practice prescribing lead worked closely in conjunction with the local clinical commissioning group (CCG) and the practice participated in prescribing audits and reviews.

Cleanliness and infection control

Systems were in place to reduce the risks of the spread of infection. We observed the premises to be clean and well maintained. We saw there were cleaning schedules in place and that daily cleaning records were kept. Patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness or infection control.

The nurse manager was the lead nurse for infection control. They had last received training appropriate to their role in January 2014. This enabled them to provide advice on the practice infection control policy and to carry out staff training. All staff had received training in infection control processes and were aware of infection control practices. The nurse manager had provided staff with hand hygiene awareness update training in November 2014. Nurses had undertaken infection control update training with an external provider in February 2015.

Infection control policies and procedures were in place. An audit of infection control processes had been carried out by the lead nurse in November 2014. We saw that the practice had developed an action plan to address the findings of the audit. Areas identified as requiring action

had been followed up or reviewed. For example, holders for gloves and aprons and sharps bins had all been wall mounted in response to the audit findings. The lead nurse had ensured that findings of the audit had been shared within the staff team. For example, the audit findings had been discussed at clinical and team meetings. The lead nurse had circulated written reminders to the nurses and GPs of their need to remain bare below the elbows in order to minimise the risk of spread of infection.

Hand washing notices were displayed in all consulting and treatment rooms. Hand wash solution, hand sanitizer and paper towels were available in each room. Disposable gloves were available to help protect staff and patients from the risk of cross infection. Spillage kits were available within the practice.

We saw that the practice had arrangements in place for the segregation of clinical waste at the point of generation. Colour coded bags were in use to ensure the safe management of healthcare waste. An external waste management company provided waste collection services. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles.

Suitable arrangements were in place to reduce the risks of exposure to Legionella bacteria which is found in some water systems. A Legionella risk assessment had been completed in November 2014 and systems for the regular monitoring of water supplies were in place.

Equipment

Staff we spoke with told us they had sufficient 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. A schedule of testing was recorded. We saw evidence that testing of electrical items and calibration of relevant equipment had been carried out in September 2014. For example, digital blood pressure machines and weighing scales.

Records showed essential maintenance was carried out on the main systems of the practice. For example the boilers and fire alarm systems were serviced in accordance with manufacturers' instructions.

Staffing and recruitment

The practice had developed comprehensive and robust systems for the monitoring of staffing levels linked to service planning. Staff told us there were always appropriate numbers of staff on duty and that staff rotas were managed well. There was a system for members of staff, including GPs and administrative staff, to cover annual leave. Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

We examined personnel records and found that the practice had ensured that appropriate recruitment checks were undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body. The practice had a comprehensive series of recruitment policies which set out the standards it followed when recruiting clinical and non-clinical staff. We saw that these policies were due to be reviewed in October 2015. The practice had undertaken risk assessment of all roles within the practice to determine the need for criminal records checks through the Disclosure and Barring Service (DBS). As a result, where required, staff had been subject to a criminal records check. We saw evidence of these checks.

Monitoring safety and responding to risk

The practice was located in modern, purpose built premises with good access for disabled patients. We observed the practice environment was organised and tidy. Safety equipment such as fire extinguishers and the defibrillator were checked regularly and sited appropriately.

The practice had systems and processes to manage and monitor risks to patients, staff and visitors to the practice. These included a fire risk assessment and the risks associated with exposure to legionella bacteria which is found in some water supplies. The practice had a comprehensive series of health and safety policies. Health and safety information was readily available to staff. We saw that the latest health and safety risk assessment had been carried out in April 2015.

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 patients with long term conditions and those with complex needs there

Good

Are services safe?

were processes to ensure these patients were seen in a timely manner. Staff told us that these patients could be urgently referred to a GP and offered longer appointments when necessary.

Arrangements to deal with emergencies and major incidents

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

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Staff were able to give examples of occasions when they had responded to an emergency within the practice, such as a patient who had collapsed.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. We saw that the business continuity plan had last been reviewed in November 2014. Records showed that fire alarms were routinely tested. The practice had recently carried out a full evacuation of the premises.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and the nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and that these were reviewed when appropriate.

GPs within the practice held lead roles in specialist clinical areas such as diabetes, sexual health and dermatology. We spoke to the nurse manager who was the nurse lead for diabetes within the practice. They described a culture of continuous learning and improvement with encouragement to attend regular clinical meetings. The nurse practitioner told us that they attended a local diabetes forum and educational sessions and as a result had developed relationships with local consultants with whom they were able to share and receive information.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. GPs used national standards and best practice for all referrals to secondary care. For example, patients requiring a referral into secondary care with suspected cancers were referred and seen within two weeks.

The practice ensured that patients had their needs assessed and care planned in accordance with evidence based best practice. We saw that patients received appropriate treatment and regular review of their condition. For example, the practice nurses managed the care of a number of patients with venous leg ulcers. The nurses worked closely with the local tissue viability nurse in the on-going assessment and management of those patients. The practice nurses had received training in four-layer bandaging and the use of compression hosiery in order to provide optimum care to the patients.

The practice held a register of patients receiving end of life care and held monthly palliative care meetings with the local hospice team. Patients with palliative care needs were supported using the Gold Standards Framework. One healthcare assistant told us they had been appointed as the palliative care coordinator. They worked closely with the lead GP for palliative care to maintain a register of patients receiving end of life care and ensured accurate information sharing with external services, such as out of hours services.

The practice used computerised tools to identify and review registers of patients with complex needs. For example, patients with learning disabilities or those with long term conditions. The practice nurses told us that the practice provided support and review of patients with long term conditions according to their individual needs. The practice sent invitations to patients for review of their long term conditions.

GPs and nurses were clear about how they would apply the Mental Capacity Act 2005 (MCA) and how they would assess mental capacity. Patients who were either unable or found it difficult to make an informed decision about their care could be supported appropriately.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed the culture in the practice meant patients were referred to other services based upon need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice held key roles in the monitoring and improvement of outcomes for patients. These roles included data input and quality, clinical review scheduling, long term condition management and medicines management. The information staff collected was used to determine clinical audits.

The practice had systems in place for completing clinical audit cycles. 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, the practice had undertaken a completed audit cycle to review the body mass index and glucose

Good

Are services effective?

(for example, treatment is effective)

tolerance of patients with polycystic ovarian syndrome. The audit had taken into consideration relevant best practice guidance and current research relating to the management of patients with polycystic ovarian syndrome. As a result of the audit the practice had reviewed its protocol for the management of those patients and the recall processes for ensuring regular blood testing. Other clinical audits undertaken included a review of patients undergoing cervical cytology and a review of patients prescribed a particular anti-sickness medicine in response to an alert issued by the medicines and healthcare products regulatory agency (MHRA).

The practice achieved 99.1% of the maximum Quality and Outcomes Framework (QOF) results 2014/15. The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. QOF data showed the practice performed well in comparison to the regional and national average. For example, the number of patients with diabetes who had received an influenza immunisation was recorded as 96.96%, with the national average being 93.5%. The percentage of patients with diabetes whose last measured total cholesterol was five mmol/l or less was 87.79% compared with a national average of 81.6%. The practice was not an outlier for any QOF clinical targets.

The GPs and nurses we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Regular clinical meetings provided GPs and nurses with the opportunity to regularly review outcomes, new guidance and alerts and for the dissemination of information. The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around education, audit and quality improvement.

Effective staffing

Practice staffing included GPs, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending mandatory training courses such as basic life support and training in adult and child safeguarding procedures.

The practice had identified GPs to undertake lead roles in clinical areas such as diabetes, end of life care and sexual health. All GPs were up to date with their yearly continuing professional development requirements and had either 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 practice and remain on the performers list with NHS England).

Staff we spoke with told us they had participated in regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. They told us that this had included a detailed review of performance and the setting of objectives and learning needs. We examined personnel files which confirmed this. Processes for appraisal were robust. Each staff member's review of performance and setting of objectives was recorded under specific headings such as 'building the business', 'patient experience' and 'risk'. Targets set were specific and measurable. For example, we saw that managers were set targets to achieve improvements in specific areas of the GP national patient survey and QOF targets. The practice manager had recently undergone appraisal with the executive GP partner of the practice. Their appraisal was related specifically to the key business objectives for the practice and represented the annual business plan. This was linked directly with the practice's three year strategic plan. One nurse we spoke with who had been recently recruited to the practice told us they had undergone a formal review of their performance three and six months after starting in their role. Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. We spoke with three practice nurses and two healthcare assistants who told us the practice supported education and on-going professional development. They described a culture of continuous learning and improvement, with encouragement to attend regular clinical meetings. The nurse manager was responsible for planning the training of the nurse team and we saw that a comprehensive training matrix was in place. The nursing team were able to attend additional training in specialist areas such as spirometry, cervical screening and immunisations. Those nurses with extended roles had undertaken advanced training in the management of conditions such as chronic obstructive pulmonary disease, asthma and diabetes. One healthcare assistant told us how they had been supported in progressing from a receptionist/phlebotomist role to

Good

Are services effective?

(for example, treatment is effective)

complete a national vocational qualification (NVQ) level three in care in order to support their role as a healthcare assistant. They had progressed further to undertake training at foundational degree level and had recently been encouraged by the practice to apply for nurse degree level training.

Practice nurses participated in monthly nurse meetings which provided them with the opportunity to receive and share information within the team. Information about complaints and significant events was shared with the nurse team by the nurse manager who attended management team meetings. The practice nurses and healthcare assistants participated in a mentoring system which meant they were each allocated a mentor from within the team. This provided them with individual support and the opportunity for additional supervision. Each nurse met regularly with their mentor. The nurse manager encouraged all members of the practice nurse team to maintain a comprehensive record of all their training and development activities. We saw that each nurse held a folder of all professional activities which they kept regularly updated. Nurses told us that high levels of attention to detail were paid to all areas of service planning and staff support and training within the practice.

Working with colleagues and other services

We found the practice worked with other service providers to meet patient needs and manage complex cases. The practice effectively identified patients who needed on-going support and helped them plan their care. The practice worked closely with the local neighbourhood support team which was comprised of district nurses, advanced care nurse practitioners and community care services. The neighbourhood support team worked with people with long term conditions and their carers to actively promote health and wellbeing in the community and where possible prevent unplanned admission to hospital.

Multi-disciplinary team meetings were held on a monthly basis. A range of patients were discussed within those meetings including children of concern to health visitors, those experiencing poor mental health and 'at risk' patients including patients who had experienced or were at risk of unplanned admission to hospital.

The practice had recently participated in a programme to improve patient care and access to primary care services for patients living in local nursing and residential homes. One GP from the practice had been identified as the lead for the project and had worked closely with other local practices and care homes to implement and review the project objectives. Those objectives included an increased presence of a local GP at the care homes at various times during the week, the development of individualised care plans and a reduction in unplanned admissions and out of hours care needs. The project had been subject to an interim review. The review indicated that the project had resulted in a decrease in the number of home visit requests due to the increased presence of a GP within the homes. The project had provided the opportunity for medication review and optimisation. The interim review indicated that as a result, five-ten percent of patients had medication tapered, reviewed or stopped completely. The practice told us that the project had greatly improved communication between the care homes and the practice which had led to improved patient care.

The practice also worked closely with a local specialist school to provide care to young patients with a range of behavioural, emotional and social support needs. One GP from the practice provided weekly visits to the school to provide support and care to those patients.

Blood results, hospital discharge summaries, accident and emergency reports and reports from out of hours services were seen and action taken by a GP on the day they were received. In the absence of a patient's named GP, the duty GP within the practice was responsible for ensuring the timely processing of these reports. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting upon any issues arising from communications with other care providers on the day they were received.

Information sharing

The practice used several electronic systems to communicate with other providers and for making referrals. 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.

The practice had systems to provide staff with the information they needed. Staff used the 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

Good

Are services effective?

(for example, treatment is effective)

from hospital, to be saved in the system for future reference. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. Patients consented for specific interventions by signing a consent form. Patient's verbal consent was also documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure discussed with the patient.

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The GPs and nurses we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with more complex needs, for example dementia or long term conditions, were supported to make decisions through the use of care plans, which they were involved in agreeing. However, it was not clear how frequently the practice planned to review each care plan and there was not always a specific planned date for the next review indicated within each plan.

Health promotion and prevention

GPs we spoke with told us that regular health checks were offered to those patients with long term conditions. We saw that medical reviews for those patients took place at appropriately timed intervals. Patients with long term conditions were encouraged to set goals in order to manage their condition and promote their wellbeing which were reviewed with the practice nurses. The practice also offered NHS Health Checks to all its patients aged 45 to 75 years.

The practice had 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 provided annual checks for these patients. Nurses told us they were able to signpost patients to local health and wellbeing services, for example to support patients in maintaining a healthy weight, smoking cessation or reducing their alcohol intake.

The practice offered a full range of immunisations for children, some simple travel vaccines, flu and shingles vaccinations in line with current national guidance. We reviewed our data and noted that 98.2% of children aged up to five years who attended the practice, had received their first dose of the measles, mumps and rubella vaccination. Data we reviewed showed that 96.96% of patients with diabetes had a flu vaccination within the six month period between September and March. This was higher than the national average of 93%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received seven completed cards and all were positive about the service experienced. Patients said they felt the practice offered a caring service and staff were efficient, helpful and took the time to listen to them. They said staff treated them with dignity and respect. We also spoke with four 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. Two of the comment cards described the excellent care received in managing multiple health problems.

We reviewed GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 92.79% of patients rated their overall experience of the practice as good. The practice was above average for its satisfaction scores on consultations with doctors, with 90.59% of practice respondents saying the GP was good at treating them with care and concern. This was compared with a national average of 85.31%. We also noted that 95.03% of patients had responded that the nurse was good at treating them with care and concern, compared with a national average of 90.47%.

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 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 patient treatment in order that confidential information was kept private. The main reception area and waiting room were combined but patients were requested to wait before coming forward to the reception desk. The practice had recently introduced a ticketing system and seated waiting area for patients waiting to speak to a receptionist at the reception desk.

Staff were able to give us practical ways in which they helped to ensure patient confidentiality. This included not having patient information on view, speaking in lowered tones and asking patients if they wished to discuss private matters away from the reception desk. A private room was available to patients for this purpose.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 85.88% of practice respondents said the GP involved them in care decisions and 82.6% felt the nurse was good at involving them in decisions about their care.

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.

Patient/carer support to cope emotionally with care and treatment

The results of the national GP survey showed that 90.59% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 95.03% of patients said the nurses were also good at treating them with care and concern. Patients we spoke with on the day of our inspection and some of the comment cards we received gave examples of where patients had been supported.

The practice held a register of patients who were carers and new carers were encouraged to register with the practice. The practice computer system then alerted GPs and nurses if a patient was also a carer. We saw written information

Good

Are services caring?

was available for carers to ensure they understood the various avenues of support available to them. Notices in the patient waiting room and patient website signposted patients to a number of support groups and organisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs. The 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. The practice partners attended monthly cluster group meetings with the CCG and other practices for this purpose. The needs of the practice population were well understood and systems were in place to address identified needs in the way services were delivered.

The practice worked closely with local residential homes to provide care and support to the residents. For example, the practice had recently participated in a programme to improve patient care and access to primary care services for patients living in local nursing and residential homes. One GP from the practice had been identified as the lead for the project and had worked closely with other local practices and care homes to implement and review the project objectives. Those objectives included an increased presence of a local GP at the care homes at various times during the week, the development of individualised care plans and a reduction in unplanned admissions and out of hours care needs. The project had been subject to an interim review. The review indicated that the project had resulted in a decrease in the number of home visit requests due to the increased presence of a GP within the homes. The project had provided the opportunity for medication review and optimisation. The interim review indicated that as a result, five-ten percent of patients had medication tapered, reviewed or stopped completely. The practice told us that the project had greatly improved communication between the care homes and the practice which had led to improved patient care.

The practice also worked closely with a local specialist school to provide care to young patients with a range of behavioural, emotional and social support needs. One GP from the practice provided weekly visits to the school to provide support and care to those patients.

The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment. The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. The practice invited representatives from social services, mental health, district nursing, the community matron and local hospice teams.

Patients with learning disabilities were well supported by the practice. Nurses told us that they wore their own clothes when providing care to patients with learning disabilities in order to make the patients feel more at ease. Information leaflets with large print and images were utilised in order to improve levels of understanding.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. The practice had an active patient participation group (PPG) which met regularly and with whom the practice worked closely. The practice manager showed us the analysis of the last patient survey, conducted in January 2014 which was considered in conjunction with the PPG. We saw that 638 patients had completed a survey. The results and actions agreed from the survey were available on the practice website.

Overall, there was a positive response to the survey with 89% of respondents rating their overall satisfaction with the practice as good or very good. The survey had specifically asked patients if they considered that improvements to the queuing system in reception were required. The survey indicated that of the 57% of patients who felt that changes were required, 50% wanted a ticketing system. The practice had introduced a ticketing system for patients waiting to speak to a receptionist, together with a horseshoe shaped seating area in order that patients did not have to stand whilst waiting.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Vulnerable patients were well supported. The practice provided care and support to patients with a learning disability and worked closely with community services to support their needs.

The practice was located in modern purpose built premises. The premises and services had been adapted to meet the needs of patients with disabilities. Access to the premises by patients with a disability was supported by an automatic door and accessible front reception desk which had been installed with wheelchair users in mind. The waiting area was large enough to accommodate patients

Good

Are services responsive to people's needs?

(for example, to feedback?)

with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. We noted there were car parking spaces for patients with a disability. Toilet facilities were accessible for all patients and contained grab rails for those with limited mobility and an emergency pull cord. Baby changing facilities were available for mothers with young babies.

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

Access to the service

The practice was open from 8.00am until 6.00pm on weekdays. Extended hours were available on Wednesday evenings from 6:30pm to 8.30pm and on Saturday mornings from 8.30am until 11.05am. There were online facilities for patients to book appointments. The practice had also introduced an automated telephone appointment booking system which was available to patients 24 hours a day, seven days a week. Appointments could be booked up to eight weeks in advance for nurse appointments and up to 13 weeks in advance for GP appointments. Appointments could also be booked on the day. The practice manager told us that approximately 40% of all appointments were booked on the day. A number of urgent appointments were available on the day. The practice provided a system of GP led triage for patients requesting urgent appointments. Patients received a call back form the GP to assess their need to attend the practice.

The results from a recent GP patient survey indicated that 79.74% of respondents said they found it easy to get through to the practice by phone.

Information was available to patients about appointments on the practice website. This included how to arrange home visits, how to book appointments and the number to call outside of practice hours. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Patients were advised to call the out of hours' service.

Patients spoken with and comments left on CQC comment cards confirmed that patients were mainly happy with the appointment system. Patients told us they were happy with the practice's appointment system and GP led triage system and were usually able to obtain an appointment to meet their needs. The results from a recent GP patient survey indicated that 92.9% of patients were very satisfied or fairly satisfied with the practice's opening hours.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. There were posters in the waiting rooms to describe the process should a patient wish to make a compliment, suggestion or complaint. Information was also advertised in the practice leaflet and website. 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 made a complaint about the practice.

We looked at the complaints log for those received in the last twelve months and found these were all discussed, reviewed and learning points were noted. Complaints were discussed at clinical meetings, partners meetings and practice team meetings. The practice reviewed complaints on an annual basis to detect themes or trends. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of staff.

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. The practice was clinically well led with a core ethos to deliver the best quality clinical care whilst maintaining a high level of continuity.

We spoke with 19 members of staff and they all knew and understood the vision and values and were clear about what their responsibilities were in relation to these.

The practice had developed a clear strategy which was supported by a three year strategic plan and an annual business plan, both of which were directly linked with the practice manager/business partner's annual appraisal and objectives.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. All policies and procedures we looked at had been reviewed recently and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with or above national standards. We saw that managers were set targets within their appraisal to achieve improvements in specific areas of the GP national patient survey and QOF targets.

A series of regular meetings took place within the practice which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team.

These included weekly GP partner meetings, clinical review meetings with GP's, nurses and healthcare assistants and regular team meetings which included administration and reception staff. Whole practice team meetings were held approximately twice each year. We looked at minutes from the most recent meetings and found that performance, quality and risks had been discussed. We saw evidence of good sharing of information between meetings. The attendance of team managers at GP partners meetings and management meetings ensured the effective dissemination of information to their individual teams. For example, the nurse manager regularly attended the weekly GP partners' meetings and shared relevant information to the nurse team within their monthly meetings.

We saw that records of incidents were completed in a comprehensive and timely manner and that there was appropriate action taken as a result. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nurses, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

The practice had systems in place for completing clinical audit cycles. 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). For example, the practice had undertaken a completed audit cycle to review the body mass index and glucose tolerance of patients with polycystic ovarian syndrome. The audit had taken into consideration relevant best practice guidance and current research relating to the management of patients with polycystic ovarian syndrome. As a result of the audit the practice had reviewed its protocol for the management of those patients and the recall processes for ensuring regular blood testing. Other clinical audits undertaken included a review of patients undergoing cervical cytology and a review of patients prescribed a particular anti-sickness medicine in response to an alert issued by the medicines and healthcare products regulatory agency (MHRA).

The practice had systems and processes to manage and monitor risks to patients, staff and visitors to the practice. These included a fire risk assessment and the risks associated with exposure to legionella bacteria which is found in some water supplies. The practice had a comprehensive series of health and safety policies. Health and safety information was readily available to staff. We saw that the latest health and safety risk assessment had been carried out in April 2015.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice. They had the opportunity to raise issues at any time with the GP partners, the practice manager or their line manager and were happy to do so.

Are services well-led?

Good

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

The practice had developed a clear leadership structure which included named members of staff in lead roles. For example, there was a lead GP for sexual health and one GP partner was the lead for child and adult safeguarding. A nurse manager, patient services manager, reception manager and administration manger worked alongside the practice manager/business partner. Staff were aware of the leadership structure within the practice. Reception, administration staff and nurses we spoke with were clear about their own roles and responsibilities.

High levels of attention to detail were paid to service planning and the management and support of staff. For example, the practice had developed comprehensive and robust systems for the monitoring of staffing levels linked to service planning. Nurse training, development and mentoring programmes were well documented and monitored. Staff told us they felt valued, well supported and empowered to fulfil their roles to a high standard. Staff we spoke with were able to give examples of ways in which their feedback had been responded to directly. For example, the nurse manager was regularly encouraged to review the workload and constraints upon the nurse team in order to inform future service planning and the review of staffing levels.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and whistleblowing policies which were in place to support staff. Staff we spoke with knew where to find these policies if required. Staff told us that a series of key policies were re-circulated to all staff by the practice manager on a six-monthly basis in order to ensure their understanding and awareness of the policies. Those included for example policies on whistleblowing, complaints, confidentiality, safeguarding of children and vulnerable adults and consent. Staff were required to sign to confirm they had read and understood the policy update.

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

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. The practice had an active patient participation group (PPG) which met regularly and with whom the practice worked closely. The practice manager showed us the analysis of the last patient survey, conducted in January 2014 which was considered in conjunction with the PPG. We saw that 638 patients had completed a survey. The results and actions agreed from the survey were available on the practice website.

Overall, there was a positive response to the survey with 89% of respondents rating their overall satisfaction with the practice as good or very good. The survey had specifically asked patients if they considered that improvements to the queuing system in reception were required. The survey indicated that of the 57% of patients who felt that changes were required, 50% wanted a ticketing system. The practice had introduced a ticketing system for patients waiting to speak to a receptionist, together with a horseshoe shaped seating area in order that patients did not have to stand whilst waiting.

The practice gathered feedback from staff through informal discussions and via team meetings. Staff told us they felt able to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged within the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff. Staff we spoke with were aware of the policy and how they could whistleblow internally and externally to other organisations.

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 spoke with 19 staff members and they confirmed they participated in regular appraisals which identified their training and personal development needs. Staff told us that the practice was very supportive of training and education.

Nursing staff reported that training was available in order for them to maintain and update their skills and they were well supported to attend training events. The practice had appointed a nurse manager who provided clinical, training and developmental support to the nursing team.

The practice had completed reviews of significant events and other incidents. These were shared with staff via meetings to ensure the practice improved outcomes for patients. GP and nurses were able to describe their involvement in significant events and incidents which had taken place and the learning involved. For example, the

Are services well-led?

Good

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

practice had recently reviewed their protocol for the management of patients with suspected deep vein thrombosis in response to one incident. Current best practice guidance had been circulated within the practice and included within GP induction information.