

Essington Medical Centre

Quality Report

Essington Medical 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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Essington Medical Centre, on 1 April 2015. Overall Essington Medical Centre 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 make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.

- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Not all staff had received training specific to their role in safeguarding, infection control and the role of a chaperone.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said that on most occasions they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

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

Importantly the provider should:

- Review systems in place to ensure that all staff have received appropriate training in safeguarding, infection control and the role of a chaperone.
- Complete a comprehensive infection control audit.

- Review recruitment procedures to ensure that all staff who are involved in the direct care of patients such as providing treatment or chaperone duties are risk assessed to determine if a Disclosure and Barring Service (DBS) check is required.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. We found that not all staff had attended training related to safety. This included areas such as safeguarding, infection control and prevention and chaperone training appropriate to their role. A comprehensive infection control audit had not been completed. The practice had not reviewed recruitment procedures to ensure that all staff who were involved in the direct care of patients such as providing treatment or chaperone duties were risk assessed to determine if a Disclosure and Barring Service (DBS) check was required. There were enough staff to keep patients safe.

Good



Are services effective?

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 National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Not all staff had received training specific to their role in safeguarding, infection control and the role of a chaperone. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

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

Good



Are services responsive to people's needs?

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. Patients said they found it easy to make an appointment with a

Good



Summary of findings

named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available, easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

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 supported by management. 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. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active and the practice engaged well with the group. The practice used feedback from the PPG to improve the service provided to patients. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



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

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice provided a service to two care homes.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. The practice had 443 patients with long term conditions and 95% of these had received an annual review. 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.

Good



Families, children and young people

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

Good



Working age people (including those recently retired and students)

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

Good



Summary of findings

been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice had systems in place to ensure that they could identify patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks and offered longer appointments to people with a learning disability and all of these patients had received a follow-up.

Good



People experiencing poor mental health (including people with dementia)

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

Good



Summary of findings

What people who use the service say

We spoke with eight patients during our inspection, three of whom were members of the practice patient participation group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. We spoke with and received comments from patients who had been with the practice for a number of years and patients who had recently joined the practice. Patients we spoke with during the inspection were extremely positive about the service they received. They told us that they were treated with respect, never rushed and were listened to. Patients described the staff and GPs as always helpful, polite and professional.

We reviewed 13 patient comment cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that the majority of comments made were positive about the service they experienced. Patients said that they always received good treatment, patients described their experience as wonderful and told us that staff were very kind and considerate.

The January – March 2014 and July – September 2014 national GP patient survey showed that practice performed well in all areas. These included:

- 97% of respondents said that they found it easy to get through the surgery by phone as compared with the local CCG average of 80%.
- 93% of respondents described their experience of making an appointment as good as compared with the local CCG average of 77%.
- 89% of respondents said that they would recommend the practice to others as compared with the local CCG average of 77%.
- 100% of respondents said that they had confidence and trust in the last nurse they saw or spoke to as compared with the local CCG average of 98%.
- 95% of respondents said that the last nurse they saw or spoke to was good at treating them with care and concern as compared with the local average of 92%.
- 92% of respondents said that the last nurse they saw or spoke to was good at explaining tests and treatments as compared with the local average of 91%.

Areas for improvement

Action the service SHOULD take to improve

- Review systems in place to ensure that all staff have received appropriate training in safeguarding, infection control and the role of a chaperone.
- Complete a comprehensive infection control audit.
- Review recruitment procedures to ensure that all staff who are involved in the direct care of patients such as providing treatment or chaperone duties are risk assessed to determine if a Disclosure and Barring Service (DBS) check is required.

Essington Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team also included two specialist advisors a GP, a practice manager, and an Expert by Experience. An Expert by Experience is someone who has extensive experience of using a particular service, or of caring for someone who has.

Background to Essington Medical Centre

Essington Medical Centre Wolverhampton is situated within an area of lower deprivation when compared to other areas in the local CCG area of Cannock Chase. The practice is listed as having a patient list size of approximately 2,300 patients. Their main population groups are evenly distributed across all age groups, with a higher than local average number of patients within the 65 plus age group. The opening times at the practice are between 8am and 6.30pm Monday to Friday. Patients can book appointments in person, on-line or by telephone. Extended hours are available on Tuesday evenings between the hours of 6.30pm and 7.30pm.

The team of clinical staff at Essington Medical Centre consists of two GP Partners and three salaried GPs (three male and two female), a practice nurse and a clinical support worker. A business manager, practice manager, reception, administrative and secretarial staff provide the practice with administration staffing support.

The practice provides services to patients of all ages based on an Alternative Provider Medical Services (APMS) contract with NHS England for delivering primary care services to

their local community. APMS provides the opportunity for locally negotiated contracts with non-NHS bodies, such as voluntary or commercial sector providers, (or with GMS/ PMS practices) to supply enhanced and additional primary medical services. Services provided at Essington Medical Centre include the following clinics; family planning, new patient medicals, asthma, diabetic, child immunisations and wellbeing screening clinics.

Badger provides an out of hours service for patients when the practice is closed and information is provided to patients about the NHS 111 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Before our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We asked NHS England, Cannock Chase CCG and the local Healthwatch to

Detailed findings

tell us what they knew about Essington Medical Centre and the services they provided. We reviewed information we received from the practice prior to the inspection. The information we received did not highlight any areas of risk across the five key question areas.

We carried out an announced visit on 1 April 2015. During our visit we spoke with a range of staff including GPs, practice manager, practice nurse and reception and administration staff. We spoke with eight patients and members of the patient participation group (PPG) who used the service. We observed how patients were being cared for and talked with carers and/or family members. We reviewed surveys and comment cards where patients shared their views and experiences of the service.

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

- Is it safe?

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

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

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

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 with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we saw that an incident had occurred whereby one of the fridges containing medicines had been left open overnight. We saw that appropriate action had been taken and the issue raised as a significant event. Following analysis of the significant event we saw that procedures for checking the fridge were reinforced and policies updated.

We reviewed safety records, incident reports and minutes of monthly significant event meetings where these were discussed. We saw that the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. The practice manager was responsible for disseminating safety alerts and there were systems in place to ensure they were acted on.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring safety incidents. These were collated by the practice as significant events. There were records of significant events that had occurred during the last year and we were able to review these. Records we examined detailed 12 significant events that had occurred over the past 12 months. We saw that significant events were a standing item on the practice meeting agenda. There was evidence that the findings were shared with relevant staff. The minutes of the meetings showed that they were attended by both clinical and non-clinical staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. We saw that significant event reports detailed the event, the outcome of investigations, action to be taken to prevent reoccurrence and details of the learning shared with all staff. Staff we spoke with confirmed this.

Staff used significant event forms and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. Of the 12

significant events we tracked six and saw records were completed in a timely manner. Staff we spoke with told us that a review of practice had been implemented for example following incidents where a needle stick injury had occurred and as a result of medication errors. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at monthly staff meetings to ensure all staff were aware of any action they needed to take. We saw that following an alert regarding the use of a medicine used for pain relief that patients were called in for a review of their medication to ensure they received the correct dosage of these medicines.

We saw that significant events were followed up and referred or shared with other professional agencies outside the practice where appropriate. The local Clinical Commissioning Group (CCG) who monitored the performance of the practice told us they had no concerns about this practice. The CCG are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records which showed that not all staff had received relevant role specific training on safeguarding. The lead GP for safeguarding and the management team were aware that some staff had not completed safeguarding training and told us that they would be addressing this. However staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible and displayed throughout the practice.

Are services safe?

The dedicated GP was the lead for safeguarding vulnerable adults and children. We found that the GP had the necessary training to enable them to fulfil this role. All staff we spoke with were aware of who the lead was and who to speak with in the practice if they had a safeguarding concern. The GP told us they worked closely with the health visiting service to support children and their families. There was a system in place that ensured that the health visiting service was made aware of new children who registered with the practice.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy for staff and information for patients on the role of a chaperone. A poster for patients was visible in the waiting room area however information was not available for patients in the consulting rooms. This would act as a reminder to patients that this service was available to them and that they could request a chaperone. Staff were clear on what their role involved when acting as a chaperone. Staff knew where to stand and were clear of the observations they should make. Patients we spoke with told us that they had been offered a chaperone when needed. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure).

All staff carried out chaperoning duties including administration and reception staff. The practice could not confirm during the inspection that all staff had DBS criminal record checks in place or that risk assessments had been completed to ensure they were suitable to undertake the role of a chaperone. DBS checks are carried out to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Following our inspection the practice manager sent us information to confirm that these staff had had a DBS check or a risk assessment completed. Staff told us they had not received formal chaperone training to help them to understand their responsibilities when acting as chaperones. However, staff did recognise the need to be able to clearly observe the examination and were aware of what action to take if they had any concerns.

Medicines management

We checked the medicines stored in the medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. A log of the fridge temperature ranges had been recorded twice daily which demonstrated that vaccines stored in the fridges were safe to use because they had been stored in line with the manufacturers' guidelines. The medicine management policy also described the action to take if vaccines had not been stored within the appropriate temperature range. Practice staff we spoke with understood why and how to follow the procedures identified in the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice nurse administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw up-to-date copies of all the PGDs and evidence that the practice nurse had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were appropriate and necessary. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were appropriate and necessary. There were systems in place to check that GP prescription pads used could be tracked through the practice.

Cleanliness and infection control

Are services safe?

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy, and to carry out staff training. However the practice could not confirm that all staff had undertaken infection control and prevention training. All staff received induction training about infection control specific to their role. The practice had an infection control policy in place. We saw evidence that a hand washing audit was completed in February 2015. It was not clear that there were plans to repeat the audit or undertake other infection control related audits.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Staff told us that they were aware of the policies and where to find them if they needed to refer to them. Staff described how they would use these to comply with the practice's infection control policy. For example, personal protective equipment included disposable gloves and aprons and these were available for staff to use. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Staff told us that they were aware of the policies and where to find them if they needed to refer to them. There was a policy for needle stick injuries and staff knew what to do if an injury occurred. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested

and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw records that demonstrated all portable electrical equipment had been tested in March 2015 to ensure they were safe to use. We saw records that demonstrated that all medical devices had been calibrated in March 2015 to ensure the information they provided was accurate. This included devices such as weighing scales, blood pressure measuring devices, thermometers and ear syringes.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that most appropriate recruitment checks had been undertaken prior to employment and in line with the practice's policy. This included proof of identification, references, qualifications and registration with the appropriate professional body.

During the inspection the practice were unable to provide evidence of Disclosure and Barring Service checks (DBS) for all clinical and non-clinical staff working at the practice. DBS checks are carried out to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. There were no risk assessments to demonstrate how the practice had come to the decision that staff did not require a DBS check. However following our inspection the practice manager sent us information to confirm that these staff had had a DBS check and risk assessments were completed.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. We saw that staffing rotas were planned in advance to ensure adequate staffing levels were maintained.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We saw records that demonstrated that weekly, monthly and annual checks of the building had been carried out. This included a fire risk assessment and

Are services safe?

fire drills for staff; emergency lighting tests and fire alarm testing. We saw that multiple risk assessments for the Control of Substances Hazardous to Health (COSHH) had also been completed.

We saw that where risks were identified that action plans had been put in place to address these issues. The practice manager showed us the practice's risk management report and an agenda for an action log meeting to discuss the risks identified in the report. For example these included assessment of staff who used computer display screens, safety of medical electrical equipment and staff working alone.

There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. We saw two examples of this at the time of our inspection where one patient was referred immediately due to the symptoms they presented with, which had resulted in a rapid deterioration in their health. A second example involved the practice contacting the relatives of a patient to maintain their safety. Staff we spoke with told us that children were always provided with an on the day appointment if required.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all clinical 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 monthly to ensure it was fit for purpose.

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 (a severe allergic reaction) and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included loss of premises, adverse weather, unplanned sickness and the loss of domestic services. The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that a practice fire drill had been carried out last year. We saw that there was a yellow triangle warning sign on the door of the room where the oxygen was stored to alert the fire service of the presence of oxygen if a fire were to occur at the practice.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE). For example, one of the GPs and a nurse described how they had used the NICE guidelines for the management of patients with long-term conditions. We saw that the GPs and nurses used clinical templates in the management of patients care and treatment. This assisted them to assess the needs of patients with long term conditions for example, diabetes and asthma. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and family planning and the practice nurse supported this work, which allowed the practice to focus on specific conditions. We saw training certificates which demonstrated that the practice nurse had received the additional training they required for the review of patients with long term conditions such as asthma and diabetes. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. One of the GPs told us this supported all staff to continually review and discuss new best practice guidelines.

All the GPs we spoke with used national standards for the referral of patients with suspected cancers so that they were referred and seen within two weeks.

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

Management, monitoring and improving outcomes for people

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

The practice showed us one complete clinical audit and two reviews that had been undertaken in the last 12 months. The audit looked at patients prescribed a medicine called Tramadol. Tramadol is used to help control moderate to severe pain. This was following recommendations from the Advisory Council on the Misuse of Drugs (ACMD) after the increase in tramadol related deaths in recent years. The aim of the audit was to identify all patients registered at the practice who had been prescribed this medicine. Patients were then reviewed and their prescription updated to comply with the new legislation. After two cycles of this audit the practice were able to demonstrate that the number of patients on tramadol who had had their medicine prescribed in line with the new legislation had risen from 0% to 74%.

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 reviewed their patients diagnosed with atrial fibrillation (AF) a heart condition that causes an irregular and often an abnormally fast heart rate to ensure that they had been assessed for the risk of a stroke and had appropriate treatment commenced.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 95.6% of patients with chronic obstructive pulmonary disease and all patients with asthma had received an annual review. (COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema) These results were above the national target. The practice had also performed well in other areas this included, 84% of patients who experienced poor mental health had a plan of care implemented and 91.7%

Are services effective?

(for example, treatment is effective)

of patients with dementia had had a face to face review in the last 12 months. A further example showed that all patients with a learning disability registered with the practice had an agreed care plan in place.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients who received repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice worked in line with the gold standard framework (GSF) for end of life care. GSF sets out quality standards to ensure that patients receive the right care, in the right place at the right time. We saw that multi-disciplinary working between the practice, district and palliative care nurses took place to support these vulnerable patients. We saw there was a system in place that identified patients at the end of their life. This included a palliative care register and alerts within the clinical computer system making clinical staff aware of their additional needs.

The practice participated in local benchmarking run by the Clinical Commissioning Group (CCG). This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. This benchmarking data highlighted areas where the practice was performing well and areas they needed to improve. QOF data demonstrated that the practice consistently performed above the local and national average across all clinical areas.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that not all clinical and non-clinical staff were up to date with attending training courses such as infection control and prevention, chaperone training and safeguarding. We noted a good skill mix among the GPs, practice nurse and healthcare assistant. GPs specialist interests family planning and minor surgery. Staff had appropriate courses and qualifications in these areas. All the GPs we spoke with were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation.

(Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All nurses and healthcare assistants had supervision of their practice carried out. All staff had 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. The practice was a training practice, GP registrars who were training to be qualified as GPs had access to a senior GP throughout the day for support.

The practice nurse was expected to perform defined duties and had extended roles. The nurse was able to demonstrate that they were trained to fulfil these duties. For example, the nurse had completed appropriate training to undertake the administration of childhood immunisations, vaccinations and cervical screening. GP support was available to the practice nurse at all times.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All the staff we spoke with understood their roles and felt the system in place worked well. The practice also had specific guidelines for staff on acting on information received from the Out Of Hours service (OOHs)

The practice held three monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district nurses, palliative care nurses and decisions about care planning were documented in a shared care record.

Electronic systems were in place for making referrals, and the practice had made all referrals possible through the Choose and Book system. (Choose and Book is a national

Are services effective?

(for example, treatment is effective)

electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Patients we spoke with confirmed that they had been offered this choice. Administration staff told us that they monitored the system to check that referrals were being processed.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

A health visitor carried out a weekly baby clinic at the practice and a midwives clinic where pregnant women could be seen was held weekly at the practice.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence that the practice had used significant events to learn and improve information sharing between the practice and other providers.

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Consent to care and treatment

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We saw there was a MCA 2005 policy in place to support staff in making decisions when capacity was an issue for a patient. 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 a diagnosis of dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We saw that all of these care plans had been reviewed in the last year. When interviewed, staff gave examples of how patients' best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, there was a formal consent form for patients to sign which demonstrated they were aware of the relevant risks, benefits and complications of the procedure. Consent forms were scanned into patients' notes. We saw an anonymised record where this had been completed.

Health promotion and prevention

Patients over 75 years of age had a named GP to provide continuity of care. Childhood vaccinations and child development checks were offered in line with the Healthy Child Programme. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the local Clinical Commissioning Group (CCG), and there was a clear policy for following up non-attenders led by the practice nurse. The practice was aware that the percentage of older people who had received a seasonal flu vaccination at the practice was lower than the local CCG average and had put plans in place to address this.

There were systems in place to support the early identification of cancers. The practice carried out cervical screening for women between the ages of 25 and 64 years. We saw that the practice's performance for cervical smear uptake was 86.4% which was above the national average of 74.3%. The practice was proactive in screening for cancers such as bowel and breast cancer.

The practice nurse actively engaged their patients in lifestyle programmes. The practice had performed better than other practices in the local CCG area for monitoring

Are services effective? (for example, treatment is effective)

and supporting patients who smoked. Information showed that 92.2% of patients had their smoking status recorded and had accepted support to help them stop smoking. The practice nurse described to us how they sign posted patients to weight loss clinics and completed exercise referrals for patients who needed to manage their weight.

We saw that up to date health promotion information was displayed and easily accessible to patients' in the waiting area of the practice.

The practice ensured that patients with long-term conditions for example, diabetes had an annual health review routinely carried out. Further information also showed that the practice performed above the local and national average for the care of patients with dementia. Data available showed that 91.7% of the patients diagnosed with dementia had received face to face reviews as compared to the local and national average of 80.5% and 83.8% respectively.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from 114 replies to the national patient survey carried out during January-March 2014 and July-September 2014. The evidence showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the results from the national patient survey showed that 97% of respondents said that their overall experience of the practice was good or very good and 89% of respondents said they would recommend the practice to someone new to the area. These results were above the local CCG average. The practice was above the local CCG average for its satisfaction scores on consultations with GPs. For example, 94% of respondents said the GP was good at listening to them and 95% said the GP gave them enough time. The results also showed that patients were satisfied with their consultations with nursing staff. These were again above the local CCG average. For example, 98% of respondents said the nurse was good at listening to them and 98% of respondents said the nurse gave them enough time. The CCG are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 13 completed cards and all were positive about the service they experienced. Patients said the staff were approachable, kind and treated them with dignity and respect. They said the staff listened to them and responded to their needs and they were involved in decisions about their care. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations

and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The position of the open reception desk within the waiting room made it difficult for confidential conversations to take place. Reception staff that we spoke with were aware of the difficulties and had systems in place to maintain patient's confidentiality. These included taking patients to private rooms to continue a private conversation and transferring confidential telephone calls to a private room if a person rang the surgery for investigation results.

We saw that staff had received training in equality and diversity and that there was a policy for them to refer to. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. There was a clearly visible notice in the patient reception areas stating the practice's zero tolerance for abusive behaviour. Receptionists could refer to this to help them to manage potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. They generally rated the practice well in these areas. For example, data from the national patient survey showed 87% of practice respondents said the GP involved them in care decisions and 90% felt the GP was good at explaining treatment and results. Both these results were in line with the CCG regional average.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They told us they felt listened to and supported by staff and had sufficient time during

Are services caring?

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.

We spoke with a district nurse who worked with the practice to provide care and support to vulnerable, older patients. They told us that the practice was proactive in identifying and communicating concerns about older patients registered with the practice. They told us that they worked with the practice to involve these patients in decisions about their care.

We spoke with representatives of two care homes for older people. They told us that all the patients living there who were registered with Essington Medical Centre Surgery had a named GP and received regular medication reviews. They also told us that when a do not attempt cardio-pulmonary resuscitation (DNAR CPR) decision had been made regarding a patient, that the patient and their family were fully involved in those decisions. They told us the GPs reviewed these decisions at regular intervals with the patient and carer where appropriate. Patients were able to make decisions such as whether they wanted to receive cardio-pulmonary resuscitation in the event of severe illness. The DNAR CPR decisions must be recorded and authorised by a medical professional. There are clear guidelines and timescales to abide by and the decision must be reviewed to ensure it still stands. We found the practice staff were aware of their responsibilities in respect of appropriate processes and record keeping for DNAR CPR decisions. The practice had regular informal meetings with staff from both care homes.

Staff told us that translation services were available for patients who did not have English as a first language. This enabled them to be involved in decisions about their care.

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, 87% of respondents to the national patient survey said the last GP they saw or spoke with was good at treating them with care and concern and with a score of 95% for the nurses. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

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

The practice had written a carers policy that ensured all staff were aware of the support and services available to them. The lead GP told us that if families had suffered a bereavement, their usual GP contacted them. If necessary, they also signposted them for bereavement support and counselling provided local support organisations.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. Although the population groups were evenly distributed across all age groups information available showed that the practice had a higher than local average number of patients in the 65 plus age group. To meet some of these needs the practice provided a service to two care homes for the elderly. For example, there was effective communication between the care homes and the practice and the practice provided advice, guidance and visits to the home on request. Care plans had been completed for these patients. All patients diagnosed with dementia in the care homes and within the wider community had been reviewed. The practice had ensured that all patients with rheumatoid arthritis had received an annual face to face review.

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 CCG are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients and the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We spoke with three members of the PPG who told us that following their patient survey in 2014 the results were discussed with them. The results of the survey showed that generally patients were happy with the service they received. We saw that where concerns had been raised actions were taken to address them. For example, some patients expressed the need for an increase in appointment times. The practice had put an action plan in place to address this with the PPG in order to determine how they could meet patient's needs.

Tackling inequity and promoting equality

The practice provided equality and diversity training for all staff and we saw evidence of this. Staff we spoke with confirmed they had completed equality and diversity training.

The practice recognised the needs of different groups in the planning of its services. The practice was a single storey building. Although at times the waiting area was very busy, it was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. Facilities for patients with mobility difficulties included designated parking spaces; level access to the automatic front doors of the practice and toilets for patients with a physical disability. The practice had a small population of patients whose first language was not English; staff had access to a translation service to ensure patients were involved in decisions about their care.

The practice provided care and support to elderly patients and patients living in their own homes. Patients over 75 years of age had a named GP to ensure continuity of care. We spoke with representatives from the care homes who told us that the practice always responded quickly to a request for a patient to be seen at the home.

Access to the service

Comprehensive information was available to patients about appointments on the practice's website and in the practice leaflet. This included how to arrange routine and urgent appointments and home visits and how to cancel appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

We looked at the national patient survey results published in January 2015 and saw that 93% of respondents described their overall experience of making an appointment as good or very good. Some of the patients we spoke with and comments made in comment cards said that making appointments was sometimes difficult. The practice was aware of these concerns and in response was looking at the possibility of increasing the number of appointments available to patients.

Are services responsive to people's needs?

(for example, to feedback?)

The normal opening hours for the practice was 8am to 6.30pm. The practice also offered extended hours outside of the practice normal working hours for patients unable to attend due to work commitments or relied on other people bringing them to the practice who go to work. Extended hours were offered on a Tuesday evening between 6.30pm and 7.30pm.

The practice offered pre-bookable appointments which could be made up to two weeks in advance. These appointments were for patients who need to be reviewed by a GP on a regular basis and those who did not need to see a GP urgently. Appointments were made available for patients who wished to be seen on the same day. Longer appointments were available for patients who needed them this included those with long-term conditions. Staff told us that children and older patients were always seen on the same day that they requested an appointment.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in

line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. We saw that there was information on the practice website and a poster in the waiting room informing patients how to complain.

We looked at seven complaints received in the last 12 months. We saw that they were responded to and dealt with in a timely manner and that there was openness and transparency when dealing with them. We saw practice meeting minutes that demonstrated complaints were a regular agenda item and learning from them was shared with staff. This supported staff to learn and contribute to any improvement action that might have been required.

The practice reviewed complaints to detect themes or trends. There were no common themes identified in the seven complaints we reviewed. We looked at their annual complaints review report. We saw that lessons learned from individual complaints had been acted on.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high standards of care. The practice values included to provide people registered with the practice with high quality care and treatment and to seek continuous improvement on the health of the practice population; to recruit, retain and further develop a highly motivated and skilled workforce; to treat all patients and staff with dignity and respect.

We spoke with a number of patients, staff and other health professionals who all spoke very positively about how the practice worked to fulfil its aims. Staff and members of the PPG told us that the practice worked with them to continuously review the services provided and introduced changes if they were appropriate to meet the needs of patients. We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We saw that staff demonstrated a positive approach to their work and comments received from patients aligned with this. We spoke with representatives from two care homes where the practice provided care and support to patients and they confirmed that the practice worked in line with these values.

The practice offered services that supported improving outcomes for patients. These services included, the initiation, monitoring and reviewing of the treatment of diabetic patients, diagnostic tests which included taking bloods and carrying out an electrocardiogram (ECG) the process of recording the electrical activity of the heart, and the identification and monitoring of the 2% of patients at high risk of unplanned admission to hospital.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer at the practice. We saw that staff could easily access the policies. We looked at seven of the policies available and saw that they had been reviewed annually and were up to date. The practice collected evidence to confirm that staff had read and understood all the relevant policies in place. This was monitored by the practice

manager and was also followed up at practice meetings and through staff appraisals. Policies available included recruitment, registration of new patients, management of cervical screening and patient confidentiality.

There was strong leadership at the practice. Staff we spoke with told us they felt valued, well supported and knew who to go to in the practice with any concerns. All staff had specific roles and could demonstrate that they took these seriously. For example, there was a lead for safeguarding, health and safety and infection control.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. 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. The 2013/2014 Quality and Outcomes Framework (QOF) data we looked at showed that the practice had received a practice value of 93.5% of the points available to them. The practice had a protocol in place to effectively manage cervical screening, this included staff training and an effective call and recall system as was shown by their exception rate which was lower than the national average. We saw that QOF data was regularly discussed at monthly governance meetings.

The practice had a programme of clinical audits and reviews which it used to monitor quality and systems to identify where action should be taken. We looked at one completed audit and two reviews of procedures carried out at the practice. These demonstrated improvements in patients' outcomes. One example was a review to check safe practise was carried out when fitting a family planning device into female patients. The review looked at the total number of the family planning devices inserted and removed. The review also identified any areas where the practice performed well and where improvements could be made. The results highlighted that the problems identified were administrative and there were none that put the patient at clinical risk.

The practice had arrangements for identifying, recording and managing risks. The manager for the premises and the practice manager showed us the risk log, which addressed a range of potential issues, for example loss of the computer system. We saw that the risk log was discussed at meetings and updated in a timely way. Risk assessments had been carried out and where risks were identified action

Are services well-led?

Good 

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

plans had been produced and implemented. For example the lone working assessment identified the preventative measures staff should take to protect themselves and action to take if they felt vulnerable and at risk of harm.

The practice held monthly governance meetings to which all staff were invited. We looked at minutes from the last four meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment, harassment and bullying at work and disciplinary procedures which were in place to support staff. We were shown the staff handbook that was available to all staff which included sections on equality. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at practice meetings. Staff we spoke with knew where to find these policies if required. The practice had a whistle blowing policy which was available to all staff to access by the practice intranet. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, friends and family test, compliments and complaints received. We also looked at the results of the patient participation group (PPG) patient survey for 2013 – 2014 and saw appropriate action was taken to address comments and suggestions made by patients. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice had an active PPG which consisted of eight members. The PPG included male and female members. The PPG met quarterly with staff members and a GP from the practice. We saw an action plan had been formulated to address comments made by patients. These included a looking at increasing appointments slots available to patients and issues related to car parking.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff files we looked at demonstrated that regular appraisals had taken place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had protected learning time where guest speakers and trainers attended. We saw that there was also a buddying system for nurse and healthcare assistant and this role was fulfilled by the GPs. We saw that the practice had a training matrix that identified when staff training would need to be updated. However we found that this was not used effectively in that some staff training such as safeguarding, infection control and chaperone training had not been identified.

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

We saw that the practice worked well as a team and worked to make and sustain improvements. The practice GPs met on a weekly basis to discuss any clinical issues, guidelines or serious events. We saw evidence that where although there was a high level of performance that where there was poor performance this was addressed both through the practice staff team and the patient participation group. Staff showed they were keen to ensure ongoing improvement and addressed this as a team. An example of this was to ensure that all patients diagnosed with long term conditions received an annual review and received education that promoted self-management of their care with the support of the practice.