Drs. Howe and Hendriksz

Quality Report

Lostwithiel Medical Practice
North Street
Lostwithiel
Kernow PL22 0EF
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Website: www.lostwithielmedicalpractice.nhs.uk

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Lostwithiel Medical Practice was inspected on 21 January 2015. This was a comprehensive inspection. Overall, we rated this practice as good.

Lostwithiel Medical Practice provides primary medical services to people living in Lostwithiel and the surrounding areas. The practice provides services to a local population the vast majority of whom are Cornish and is situated in a semi rural location.

At the time of our inspection there were approximately 4,850 patients registered at the service with a team of two male GP partners, together with one female salaried GP and one trainee male GP. GP partners held managerial and financial responsibility for running the business. In addition there was a practice manager, and additional administrative and reception staff.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, visiting orthopaedic and gastroenterological services, acute care at home team, early intervention team and a community matron.

Our key findings were as follows:

We rated this practice as good. Patients reported having good access to appointments at the practice and liked having a named GP which improved their continuity of care. The practice was clean, well-organised, had good facilities and was well equipped to treat patients. There were effective infection control procedures in place.

The practice valued feedback from patients and acted upon this. Feedback from patients about their care and treatment was consistently positive. We observed a patient centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Views of external stakeholders were positive and were aligned with our findings.

Summary of findings

The practice was well-led and had a clear leadership structure in place whilst retaining a sense of mutual respect and team work. There were systems in place to monitor and improve quality and identify risk and systems to manage emergencies.

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

Suitable staff recruitment, pre-employment checks, induction and appraisal processes were in place and had been carried out. Staff had received training appropriate to their roles and further training needs had been identified and planned.

Information received about the practice prior to and during the inspection demonstrated the practice performed comparatively with all other practices within the clinical commissioning group (CCG) area.

Patients told us they felt safe in the hands of the staff and felt confident in clinical decisions made. There were effective safeguarding procedures in place.

Significant events, complaints and incidents were investigated and discussed. Learning from these events was communicated and acted upon.

We found several examples of outstanding practice. These included:

- The practice delivered outstanding dementia care. There was a GP with an interest in dementia and a dementia nurse at the practice. A GP at the practice had created dementia care guidelines which had been adapted by the local Clinical Commissioning Group (CCG). The practice had been nominated for an award because of their dementia care by the British Medical Journal. The practice had been a finalist for this award.
- The practice had been EEFO approved. (The term EEFO does not stand for anything. EEFO is a word that has been designed by young people, to be owned by young people) EEFO works with other community services to make sure they are young people friendly. The practice had a nominated EEGO GP and an EEFO nurse. Once a service has been EEFO approved it means that service has met the quality standards. For example, confidentiality and consent, easy to access services, welcoming environment and staff trained on issues young people face. Part of this scheme is the C-Card scheme. The C card is given so that a younger person can get free condoms at different places across Cornwall & the Isles of Scilly.
- The practice had proven its safeguarding processes were robust and had been commended by the local independent safeguarding chair on its effective use of these processes.
- The practice had a very low emergency admission to hospital rate compared to other practices in the locality. This was due to the long standing approach by the practice to personal care and continuity of care.
- GPs at the practice had been instrumental in bringing ultrasound services to Bodmin hospital. This enabled many patients to receive an early diagnosis of their medical conditions at a convenient local site.
- GPs and nurses had created a library of leaflets which could be provided to patients to explain specific medical conditions or procedures. These guides were based on National Institute for Health and Care Excellence (NICE) guidance. For example, leaflets were available on spirometry and blood tests.

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

- The provider should consider arrangements for recording the storage temperature of medicines and the checks made on expiry dates of products.
- The provider should ensure an infection control audit is completed at least every 12 months.

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 good for being safe. Patients we spoke with told us they felt safe, confident in the care they received and well cared for.

The practice had systems to help ensure patient safety and staff had appropriately responded to emergencies.

Recruitment procedures and checks were completed as required to help ensure that staff were suitable and competent. There was an established body of staff at the practice and a low turnover rate. Risk assessments had been undertaken to support the decision not to perform a criminal records check for administration staff.

Significant events and incidents were investigated both informally and formally. Staff were aware of the learning and actions taken.

Staff were aware of their responsibilities in regard to safeguarding and the Mental Capacity Act 2005. There were suitable safeguarding policies and procedures in place that helped identify and protect children and adults from the risk of abuse. Safeguarding processes at the practice had attracted favourable feedback from the local independent safeguarding chairman.

There were suitable arrangements for the efficient management of medicines within the practice. Checks were made on room and fridge temperatures. The provider should ensure these checks are recorded in writing.

The practice was clean, tidy and hygienic. Suitable arrangements were in place to maintain the cleanliness of the practice. However, no infection control audit had been completed in the past 12 months. There were systems in place for the retention and disposal of clinical waste.

Are services effective?

Good

The practice is rated good for being effective. Supporting data obtained both prior to and during the inspection showed the practice had effective systems in place to make sure the practice was efficiently run.

The practice had a clinical audit system in place and a high number of audits had been completed and their findings acted upon. A repeat audit had often then been undertaken. This showed that the

Summary of findings

full audit cycle was in place. For example, an antibiotics audit in October 2014 had detected that prescribers were not always aware of pharmacists opening hours. This had been corrected and the details were now easily available to staff.

Care and treatment was delivered in line with national best practice guidance. The practice worked closely with other services to achieve the best outcome for patients who used the practice. Health visitors liaised with the practice at least once every six weeks and more regularly as required.

Information obtained both during and after the inspection showed staff employed at the practice had received appropriate support, training and appraisal. GP partner appraisals and revalidation had been completed.

The practice had extensive health promotion material available within the practice and on the practice website.

Are services caring?

Good

The practice is rated as good for being caring. Data showed patients rated the practice higher than others for many aspects of care. Feedback from patients about their care and treatment was consistently positive.

We observed a patient centred culture and found evidence that staff were motivated to offer kind and compassionate care and worked to overcome obstacles to achieving this. Patients provided us with specific examples of how the practice had offered them choices and preferences were valued and acted on, for example in treatment escalation plans. Views of external stakeholders were very positive and aligned with our findings.

Patients spoke positively about the care provided at the practice. Patients told us they were treated with kindness, dignity and respect. Patients told us how well the staff communicated with them about their physical, mental and emotional health and supported their health education.

Patients told us they were included in the decision making process about their care and had sufficient time to speak with their GP or a nurse. They said they felt well supported both during and after consultations.

The practice delivered outstanding dementia care. There was a GP with an interest in dementia and a dementia nurse at the practice. A GP at the practice had created dementia care guidelines

Summary of findings

which had been adapted by the local Clinical Commissioning Group (CCG). The practice had been nominated for an award because of their dementia care by the British Medical Journal. The practice had been a finalist for this award.

Are services responsive to people's needs?

Good

The practice was rated good for being responsive. Patients commented on how well all the staff communicated with them and praised their caring, professional attitudes.

Patients told us the GPs and staff at the practice listened to them and responded to their needs. There was information provided on how patients could complain although access to this information on the practice website could be improved. Complaints were managed according to the practice policy and within timescales.

There was an accessible complaints system with evidence that complaints were resolved within a reasonable timescale to the satisfaction of the patient where possible. The nominated member of staff for managing complaints was the practice manager. Complaint leaflets were on display. Patients knew how to complain should they wish to do so.

The practice recognised the importance of patient feedback and had encouraged the development of a patient participation group to gain patients' views.

Practice staff had identified that not all patients found it easy to understand the care and treatment provided to them and made sure these patients were provided with relevant information in a way they understood.

Patients said it was easy to get an appointment at the practice and were able to see a GP on the same day if it was urgent.

GPs and nurses had created a library of leaflets which could be provided to patients to explain specific medical conditions or procedures. These guides were based on National Institute for Health and Care Excellence (NICE) guidance. For example, leaflets were available on spirometry and blood tests.

Are services well-led?

Good

The practice is rated as good for being well led. The practice had a clear vision which had quality and patient safety as its top priority. Staff at the practice told us that their over-riding ethos was to provide all our patients with the best possible care in a local setting. During our visit we found that staff welcomed the CQC inspection as an opportunity to learn where they might improve their services.

Summary of findings

Nursing staff, GPs and administrative staff demonstrated they understood their responsibilities including how and to whom they should escalate any concerns.

Staff spoke positively about working at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work.

The practice had a number of policies to govern the procedures carried out by staff and regular governance meetings had taken place. There was a programme of clinical audit in operation with clinical risk management tools used to minimise any risks to patients, staff and visitors.

Significant events, incidents and complaints were managed as they occurred and through a more formal process to identify, assess and manage risks to the health, welfare and safety of patients.

The practice sought feedback from patients, which included using new technology, and had an active patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for providing care to older people.

The practice was actively and fully participating in the enhanced service for patients over the age of 75 years. All patients had been notified of their named GP (either Dr. Howe or Dr. Hendriksz) by letter and a register of these patients was maintained.

Clinical information regarding this population group was received daily by e-mail to a secure account and acted upon promptly by staff at the practice. There was a regular item on the clinical meeting agenda held every six weeks to review patient care updates. These were attended by practice clinicians, community nurses, community psychiatric nurse (CPN) and the learning disabilities (LD) primary care liaison nurse, health visitors, cancer care community nurses and other clinicians by invitation. Clinical information and discussions from these meetings were detailed in individual patient notes.

Daily notifications of emergency hospital admissions and discharges were brought to the attention of the appropriate GP for review and action. A decision to visit would be made by the responsible GP. A visit profile would be prepared containing details of the past medical history of the preceding three months.

A proactive case register identifying the top 2% most at risk patients was under continual review. The majority of these patients were over 75 years of age. Vulnerable patients were identified based on risk and clinical judgement. Each patient was informed that they are on this register and reminded of the name of their GP and their care co-ordinator. Personalised care plans were completed by the GP with the patient. Regular reviews were carried out. Emergency hospital admissions were reviewed regularly and quarterly returns submitted to the Kernow Clinical Commissioning Group (KCCG).

The practice had been nominated for an award by the British Medical Journal due to its excellent care for patients with dementia or memory cognitive impairment. The specialist dementia nurse had regular liaison with a local charity which runs a memory cafe in the community centre on alternate Thursdays and patients and their carers were encouraged to participate.

Patients who had set out their end of life care plan had these instructions recorded clearly in their notes. Staff could access these

Summary of findings

patient instructions and respect patient's wishes. Patients who lived in their own homes had a written copy. Where relevant, these care plans had been shared with patient's nursing homes, out of hours providers.

People with long term conditions

Good

The practice is rated as good for providing care to people with long term conditions.

The practice maintained an up to date register of patients with long term conditions. The practice care register was maintained to record assessments, diagnoses, visits, medicine reviews, care plan reviews and support for those carers involved.

The practice had submitted an application for funding of a specialist nurse for patients with long-term conditions to include patients with diabetes, asthma and COPD. This application has been subject to delays in the commissioning process. In the interim, the practice has employed a nurse specialist who oversees routine reviews of all these patients and includes those at risk of developing such or other conditions, including anxiety and depression.

For patients with palliative care needs, GPs were accessible on a daily basis if needed. The practice also had access to a cancer care community nurse. This nurse, together with other community nursing teams, regularly attend practice meetings regarding patients with long term conditions. This ensured continuity of care and helped to consolidate updates on best practice.

The practice staff and GPs maintained high levels of accessibility and good communication in order to provide a consistent and effective approach in the healthcare of all vulnerable patients, but particularly for those with long term conditions.

Repeat medicine reviews for patients were undertaken daily. Those with repeat medicine authorisation had requests generated by qualified dispensing staff. There was a limit to the number of authorised repeat prescriptions and when this limit was reached the request was passed to the GP responsible that day to review all medicines. In addition, all controlled drugs were only generated by a GP. Patients with co-morbidities and multiple medicines came under this category. The practice had undertaken a review of all polypharmacy patients to ensure effective medicines are being prescribed. For example, regular medicine audits on aspirin and painkillers.

Families, children and young people

Good

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

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The practice hosted weekly antenatal clinics for those deemed to be routine and not requiring additional services only available at St. Austell hospital maternity unit. This meant the practice provided a local provision for their patients. Pop-up reminders were added to patient records on the computer system for those reaching appropriate timescales to remind clinicians to offer pertussis (whooping cough) vaccinations.

The same search and administrative system also identified new babies and reminded staff to book in these patients for their routine checks and immunisation schedule. GPs were available during the clinic or at any other time to discuss any concerns, which were then documented within patient records. A practice nurse oversees vaccination schedules and changes in these schedules. New patients to the practice were encouraged to bring the vaccination red book at the outset to ensure notes wre complete in advance of the notes arriving from the previous GP practice.

Appointments for unwell children were prioritised and receptionists knew that any request for a child aged 5 years or below should be offered an appointment the same day.

The practice had been EEFO approved. (The term EEFO does not stand for anything. EEFO is a word that has been designed by young people, to be owned by young people) EEFO works with other community services to make sure they are young people friendly. Once a service has been EEFO approved it means that service has met the quality standards. For example, confidentiality and consent, easy to access services, welcoming environment and staff trained on issues young people face. Part of this scheme is the C-Card scheme. The C card is given so that a younger person can get free condoms at different places across Cornwall & the Isles of Scilly.

In addition to achieving EEFO level 2 status, the practice discretely promoted confidentiality unless a patient's care might be compromised. Young patients would be encouraged to discuss issues with parents where appropriate.

Working age people (including those recently retired and students)

Good

The practice is rated as good for providing care to working age people.

The practice provided extended-hour appointments on Tuesdays and Thursdays to 8.00pm. These appointments were pre-bookable slots for those unable to attend during normal working hours.

Summary of findings

In addition, the practice participated in an on-line appointment booking system for those unable to contact the practice during the working day. Visiting clinicians were made aware of such availability as are patients telephoning for a routine appointment which may not necessarily be available at a time to suit the patient.

Daily phlebotomy appointments were available from 8.00am for those patients needing an early appointment before travelling to work or those needing fasting blood tests. The practice remains open through lunchtime so that services were available for those patients who could only attend in the middle of the day.

The practice newsletter identified topical issues and includes health promotion, telephone access and a variety of suggestions to help patients access all services available and include those returning to work.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for people whose circumstances may make them vulnerable.

The practice had a vulnerable patient register to identify these patients. Vulnerable patients were reviewed at monthly multidisciplinary team meetings. A counsellor was available via the practice. Staff told us that there were very few patients who had a first language that was not English, however, interpretation requirements were available to the practice and staff knew how to access these services. Reception staff were able to identify vulnerable patients and offer longer appointment times where needed and send letters for appointments.

Patients with learning disabilities were invited, by letter, to attend annually for review. The practice offered particular care to a local home for patients with learning disabilities. As with the triage system and practice awareness, these patients were given appropriate priority. The practice maintained a learning disabilities register so they can ensure these patients receive all the health checks and treatments available to them.

The practice maintains registers for those patients who may be vulnerable and held regular clinical meetings to discuss all categories. This included patients with learning disabilities, safeguarding children and adults, domestic violence, at risk of urgent admissions, at risk of falls and the homeless. There were no patients currently registered with the practice as homeless during our inspection.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for providing care to people experiencing for mental health (including people with dementia).

GPs at the practice told us that part of the advantage a rural practice has is in identifying such patients, as there are much fewer patients with mental health illnesses than in an urban setting. Patients already diagnosed with an exacerbation of difficulties were often made known within the community before the patient presents to the practice.

Practice staff were proactive in working with other local health professionals to reach out and support patients in this population group. The practice employs a memory nurse who maintains a register with regular updates on patients receiving care.

GPs were aware of, and used, the avenues for referral of patients with mental health issues. Practice clinical meetings were attended by various mental health specialists which had been welcomed by the practice. These meetings were well attended.

The practice had registered as a safe place for patients with mental health issues. This was advertised on the front reception door window and website.

The practice had strong links with a local provider of counselling services. This provided a comprehensive service for a full complement of mental health issues and notes and discharge summaries. Consultation notes and discharge letters are scanned to patient notes, and read-coded upon receipt. This enabled GPs and local counselling services to maintain a joined up approach in supporting patients.

The practice had close liaison with the Carers Association and encouraged patients to contact the service by way of leaflets and posters.

The practice employed a memory nurse with the specific responsibility for the care of patients with both dementia and memory cognitive impairment. One of the GPs gave a presentation at the British Medical Journal Primary Care Team of the Year awards in 2013. This demonstrated best practice standards in dementia care. This had been updated with subsequent data and detailed the increasing caseload with reducing emergency hospital admissions, maintaining low referral rates and deaths occurring at home.

Summary of findings

What people who use the service say

We spoke with ten patients during our inspection. We spoke with a representative of the patient participation group (PPG).

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected 34 comment cards which contained detailed positive comments.

Comment cards stated that staff listened to them and treated them with respect. Comments highlighted a confidence in the advice and medical knowledge, access to appointments and praise for the continuity of care and having enough time.

These findings were reflected during our conversations with patients and discussion with the PPG members. The feedback from patients was positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients stated they were happy, very satisfied and said they received good treatment. Patients told us that the GPs were caring, polite and professional.

Patients told us that a new telephone appointment system had been introduced at the practice approximately 18 months ago. Patients said that this system had made it easier to book an appointment by telephone.

Patients appreciated the service provided and told us they had no complaints but knew how to complain should they wish to do so.

Patients were satisfied with the facilities at the practice. Patients commented on the building being clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients found it easy to get repeat prescriptions and said they thought the website was a useful service.

Areas for improvement

Action the service SHOULD take to improve

- The provider should consider arrangements for recording the storage temperature of medicines and the checks made on expiry dates of products.
- The provider should ensure an infection control audit is completed at least every 12 months.

Outstanding practice

- The practice delivered outstanding dementia care. There was a GP with an interest in dementia and a dementia nurse at the practice. A GP at the practice had created dementia care guidelines which had been adapted by the local Clinical Commissioning Group (CCG). The practice had been nominated for an award because of their dementia care by the British Medical Journal. The practice had been a finalist for this award.
- The practice had been EEFO approved. (The term EEFO does not stand for anything. EEFO is a word that has been designed by young people, to be owned by young people) EEFO works with other community services to make sure they are young people friendly. The practice had a nominated EEGO GP and an EEFO nurse. Once a service has been EEFO approved it means that service has met the quality standards. For example, confidentiality and consent, easy to access services, welcoming environment and staff trained on issues young people face. Part of this scheme is the C-Card scheme. The C card is given so that a younger person can get free condoms at different places across Cornwall & the Isles of Scilly.

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- The practice had proven its safeguarding processes were robust and had been commended by the local independent safeguarding chair on its effective use of these processes.
- The practice had a very low emergency admission to hospital rate compared to other practices in the locality. This was due to the long standing approach by the practice to personal care and continuity of care.
- GPs at the practice had been instrumental in bringing ultrasound services to Bodmin hospital. This enabled many patients to receive an early diagnosis of their medical conditions at a convenient local site.
- GPs and nurses had created a library of leaflets which could be provided to patients to explain specific medical conditions or procedures. These guides were based on National Institute for Health and Care Excellence (NICE) guidance. For example, leaflets were available on spirometry and blood tests.

Drs. Howe and Hendriksz

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Drs. Howe and Hendriksz

Lostwithiel Medical Practice provides primary medical services to people living in Lostwithiel and the surrounding areas. The practice provides services to a homogeneous population and is situated in a semi-rural location.

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

At the time of our inspection there were approximately 4,850 patients registered at the service with a team of two male GP partners, together with one female salaried GP and one trainee male GP. GP partners held managerial and financial responsibility for running the business. In addition there was a practice manager, and additional administrative and reception staff.

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

Lostwithiel Medical Practice is open on Mondays, Wednesdays and Fridays from 8.00am until 6.30pm. On Tuesdays and Thursdays the practice is open 8am until 8pm. These early morning and late evening appointments allowed patients who were unavailable during office hours to use the practice.

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

Routine appointments are available daily and are bookable up to two weeks in advance for GP appointments and four weeks in advance for nurse appointments. Urgent appointments are made available on the day and telephone consultations also take place.

Lostwithiel Medical Practice provides regulated activities from a single location; North Street, Lostwithiel Kernow PL22 0EF. This was the address we visited during our inspection.

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.

Detailed findings

How we carried out this inspection

Before visiting Lostwithiel Medical Practice we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, the local clinical commissioning group and local voluntary organisations.

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

We carried out our announced visit on Wednesday 21 January 2015. We spoke with ten patients and a member of the patient participation group (PPG). We spoke with a range of different staff at the practice during our inspection including GPs, nurses and administration staff. We collected 34 patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients.

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

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

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care

People experiencing poor mental health

Good

Are services safe?

Our findings

Safe Track Record

The practice had a system in place for reporting, recording and monitoring significant events.

The practice kept records of significant events that had occurred and these were made available to us. For example, when staff had concerns about a possible disclosure of confidential information they had sought advice from the practice's Caldicott guardian. This had confirmed that no unauthorised disclosure had taken place and demonstrated how seriously the practice took safety.

There was evidence that appropriate learning had taken place where necessary and that the findings were communicated to relevant staff.

Staff were aware of the significant event reporting process and how they would verbally escalate concerns within the practice. All staff we spoke with felt very able to raise any concern however small. Staff knew that following a significant event, the GPs undertook an analysis to establish the details of the incident and the full circumstances surrounding it. Staff explained that these six weekly meetings were well structured, well attended and not hierarchical.

There were systems in place to make sure any medicines alerts or recalls were actioned by staff. National alerts were received by the practice manager and disseminated to staff verbally, by email and placed in the practice alerts file. These were discussed at team meetings. There were written processes to record significant events, dispensary events, any other incidents.

Patients told us they felt safe at the practice. The 2014 GP Patient Survey showed that 100% of the 138 respondents had confidence and trust in the last GP they saw or spoke to.

Learning and improvement from safety incidents

At Lostwithiel Medical Practice the process following a significant event or complaint was both informal and formalised. GPs discussed incidents daily and also at clinical meetings. GPs, nurses and practice staff were able to explain the learning from these events. Shared learning for example on the Data Protection Act 1998 had taken place following an incident.

The practice took note of and acted upon information from national safety alerts. For example, an alert regarding a type of asthma inhaler had resulted in staff checking whether any of their patients used the relevant device. Staff contacted these patients and helped them to change to a safer asthma inhaler.

Reliable safety systems and processes including safeguarding

Patients told us they felt safe at the practice and staff knew how to raise any concerns. A named GP had a lead role for safeguarding older patients, young patients and children. Staff knew who this GP was and how to refer matters to them.

The lead safeguarding GP had been trained to the appropriate advanced level which is level three. Nursing staff had been trained to level two and administration staff to level one. There were appropriate policies in place to direct staff on when and how to make a safeguarding referral. The policies included information on external agency contacts, for example the local authority safeguarding team. These details were displayed where staff could easily find them, on paper and online.

There were monthly multidisciplinary team meetings with relevant attached health professionals including social workers, district nurses and palliative care nurses where vulnerable patients or those with more complex health care needs were discussed and reviewed. Health care professionals were aware they could raise safeguarding concerns about vulnerable adults at these meetings. The practice had proven its safeguarding processes were robust and had been commended by the local authority on its effective use of these processes within the last 12 months.

Practice staff said communication between health visitors and the practice was good and any concerns were followed up. For example, if a child failed to attend routine appointments, looked unkempt or was losing weight the GP could raise a concern for the health visitor to follow up.

The computer based patient record system allowed safeguarding information to be alerted to staff in a discreet way. When a vulnerable adult or at risk child had been seen by different health professionals, staff were aware of their circumstances. Staff had received safeguarding training within the last 12 months and were aware of who the

safeguarding lead was. Staff also demonstrated knowledge of how to make a patient referral or escalate a safeguarding concern internally using the whistleblowing policy or safeguarding policy.

We discussed the use of chaperones to accompany patients when consultation, examination or treatment were carried out. A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a medical examination or treatment. Patients were aware they were entitled to have a chaperone present for any consultation, examination or procedure where they feel one is required.

The practice had a written policy and guidance for providing a chaperone for patients which included expectations of how staff were to provide assistance. Administration staff at the practice acted as chaperones as required. They understood their role was to reassure and observe that interactions between patients and GPs were appropriate and record any issues in the patient records. Records showed that all staff had received chaperone training in November 2014. The practice had liaised with the Medical Defence Union to achieve this face to face training, in four separate sessions to ensure all staff received it.

Medicines Management

We checked medicines stored in the dispensary and found that they were stored securely and were only accessible to authorised staff. Medicines requiring cold storage were stored in a medicines refrigerator and there was a clear policy for ensuring that these medicines were kept at the required temperatures. At the time of our inspection the temperature in the dispensary was within the recommended temperature range for storing medicines. However, there were no written records of temperature monitoring kept. Systems were in place to check that medicines were within their expiry date and suitable for use, although there were no written records kept of these checks. Expired and unwanted medicines were disposed of in line with waste regulations.

There were clear operating procedures in place for dispensary processes. Systems were in place to ensure all prescriptions were signed before being dispensed. The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. Any errors or incidents were recorded, monitored and actions put in place to reduce the risks of any recurrence.

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.

The construction of the controlled drugs cabinet did not meet the standards of the Misuse of Drugs (Safe Custody) Regulations. However, the cupboard was sturdy, double locked, securely fitted and located away from any external walls. 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.

Blank prescription pads and printer forms were held securely in the practice, and systems were in place to record the serial numbers to enable an audit trail to be kept.

Cleanliness & Infection Control

We left comment cards at the practice for patients to tell us about the care and treatment they receive. We received 34 completed cards. Of these, 12 specifically commented on the building being clean, tidy and hygienic. Patients told us staff used gloves and aprons and washed their hands. There was antiseptic hand gel at the front desk.

The practice had policies and procedures on infection control and well managed cleaning schedules. We spoke with the infection control lead nurse. We found that no infection control audit had been completed within the last 12 months. Staff had access to supplies of protective equipment such as gloves and aprons, disposable bed roll and surface wipes. The nursing team were aware of the steps they took to reduce risks of cross infection and had received updated training in infection control.

Treatment rooms, public waiting areas, toilets and treatment rooms were visibly clean. There was a cleaning schedule carried out and monitored. There were hand washing posters on display to show effective hand washing techniques.

Good

Are services safe?

Clinical waste and sharps were being disposed of safely. There were sharps bins and clinical waste bins in the treatment rooms. The practice had a contract with an approved contractor for disposal of waste. Clinical waste was stored securely in a dedicated secure area whilst awaiting its collection from a registered waste disposal company.

Equipment

Emergency equipment available to the practice was within the expiry dates. The practice had a system using checklists to monitor the dates of emergency medicines and equipment so they were discarded and replaced as required.

Equipment such as the weighing scales, blood pressure monitors and other medical equipment were serviced and calibrated where required. The practice had 24 hour blood pressure monitoring devices available for patients use.

Portable appliance testing (PAT) where electrical appliances were routinely checked for safety was last carried out by an external contractor in October 2014.

Staff told us they had sufficient equipment at the practice.

Staffing & Recruitment

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well.

The practice had a low turnover of staff. The practice said that when required they employed GP locums as staff cover. They used two retired GPs for this purpose who both lived locally and had a sound knowledge of the practice. GPs told us they also covered for each other during short staff absences.

The practice used a team approach where the workload for part time staff was shared equally. Each team had appointed clerical support. Staff explained this worked well but there remained a general team work approach where all staff helped one another when one particular member of staff was busy.

Recruitment procedures were safe and staff employed at the practice had undergone the appropriate checks prior to commencing employment. Clinical competence was assessed at interview. Once in post staff completed an induction which consisted of ensuring staff met competencies and were aware of emergency procedures.

Criminal record checks via the disclosure and barring service (DBS), had been completed for GPs, nursing staff and administrative staff who had direct access with patients, including those who chaperoned. Recorded risk assessments had been performed explaining why some clerical and administrative staff had not had a criminal records check.

An employee handbook was made available to all staff on joining the practice. Staff showed us this included full details of the benefits and responsibilities of their roles. There were also disciplinary procedures to follow should the need arise.

Each registered nurse Nursing and Midwifery Council (NMC) status was completed and checked annually to ensure they were on the professional register to enable them to practice as a registered nurse.

Monitoring Safety & Responding to Risk

The practice had a suitable business continuity plan which planned for the continuance of the service in the face of adverse circumstances. These included severe weather conditions, flooding, electrical failure, fire or significant data loss. The effectiveness of this plan had proved successful during the severe floods which Lostwithiel experienced in 2011. The practice had continued to deliver a service during that difficult time. The plan was reviewed on an annual basis. The plan included such details as which staff lived within a one mile radius, a flowchart of contact details and who to contact in case of emergency.

Nursing staff received any medical alert warnings or notifications about safety by email or verbally from the GPs or practice manager.

There was a system in operation to ensure one of the nominated GPs covered for their colleagues when necessary, for example home visits, telephone consultations and checking blood test results.

Arrangements to deal with emergencies and major incidents

Appropriate equipment was available and maintained to deal with emergencies, including if a patient collapsed. Administration staff appreciated that they had also been included on the basic life support training sessions.

Good

Are services safe?

There was an Automated External Defibrillator (AED) at the practice. This is a device used to resuscitate patient's hearts in the event of a cardiac arrest. Staff had received training in its use and in emergency life support on an annual basis.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

There were examples where care and treatment followed national best practice and guidelines. For example, emergency medicines and equipment held within the practice followed the guidance produced by the Resuscitation Council (UK). The practice followed the National Institute for Health and Care Excellence (NICE) guidance and had formal meetings to discuss latest guidance. Where required, guidance from the Mental Capacity Act 2005 had been followed. Guidance from national travel vaccine websites had been followed by practice nurses.

The practice used the quality and outcome framework (QOF) to measure their performance. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their GP practices. The QOF data for this practice showed they generally achieved higher than national average scores in areas that reflected the effectiveness of care provided. The local clinical commissioning group (CCG) data demonstrated that the practice performed well in comparison to other practices within the CCG area. For example, the practice maintained an up to date register of all patients in need of palliative care regardless of age. A QOF related medicines avoidance of waste audit completed in the last 12 months showed that the practice had achieved amongst the highest cash savings in the CCG.

Management, monitoring and improving outcomes for people

The practice provided a service to up to 4,850 patients. The practice told us they were keen to ensure that staff had the skills to meet patient needs and so nurses had received training including immunisation, diabetes care, cervical screening and travel vaccinations.

The practice had a very low emergency admission to hospital rate compared to other practices in the locality. This was due to a long standing proactive approach to personal care and continuity. GPs and other clinical staff at the practice met regularly with other health professionals to ensure positive outcomes for patients.

GPs in the practice undertook minor surgical procedures and joint injections in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. There was evidence of regular clinical audit in this area which was used by GPs for revalidation and personal learning purposes. For example, each GP had completed a prescribing audit to ensure patient safety and correct use of medicines in line with the latest guidance. These audits were completed every six months to ensure a full audit cycle was in place.

Effective Staffing

All of the GPs in the practice participated in the appraisal system leading to revalidation of their practice over a five-year cycle. The GPs we spoke with told us and demonstrated that these appraisals had been appropriately completed. Lostwithiel Medical Practice is a teaching practice which supports new GPs in their professional development. Both of the GPs were qualified GP trainers.

The practice manager carried out annual appraisals on administration staff. GPs carried out annual appraisals on clinical staff. Nursing staff kept up to date with their continuous professional development programme, documented evidence confirmed this. The practice manager received an annual appraisal jointly from both GPs.

There was a comprehensive induction process for new staff which was adapted for each staff role.

The staff training programme was monitored to make sure staff were up to date with training the practice had decided was mandatory. This included basic life support, safeguarding, fire safety and infection control. Staff said that they could ask to attend any relevant external training to further their development.

There was a set of policies and procedures for staff to use and additional guidance or policies located on the computer system.

Working with colleagues and other services

Minutes of clinical meetings with other health professionals showed that the practice worked effectively with other services. Examples included, mental health services, health visitors, specialist nurses, hospital consultants and community nursing.

The practice had worked effectively with learning disability nurses to produce a set of easy to understand information guides on various medical conditions.

Good

Are services effective?

(for example, treatment is effective)

Once every six weeks there was a multidisciplinary team meeting to discuss vulnerable patients, high risk patients and patients receiving end of life care. This included multidisciplinary teams such as physiotherapists, occupational therapists, learning disability nurses, health visitors, district nurses, community matrons and the mental health team.

Information Sharing

The practice worked effectively with other services. Examples given were mental health services, health visitors, specialist nurses, hospital consultants and community nursing staff. For example, the GPs shared relevant information with health visitors regarding children in need.

The practice had a new system in place with the local hospital to share information on patient's allergies and medicines.

The practice had plans in place to improve communication with the out of hours service. This would allow the Out of Hours GPs to access patient records with their consent, using a local computer system.

Consent to care and treatment

Patients told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they had sufficient time to discuss their concerns with their GP and said they did not felt rushed. Feedback given on our comment cards showed that staff always listened to patients and sought their consent prior to treatment. Patients had different treatment options discussed with them, together with the positive or possible negative effects that treatment can have.

Staff had access to different ways of recording that patients had given consent to treatment. There was evidence of patient consent for procedures including immunisations, injections, and minor surgery. Patients told us that nothing was undertaken without their agreement or consent at the practice.

Where patients did not have the mental capacity to consent to a specific course of care or treatment, the practice had acted in accordance with the Mental Capacity Act (2005) to make decisions in the patient's best interest. Staff were knowledgeable and sensitive to this subject. We were given specific examples by the GPs where they had been involved in best interest decisions and where they had involved independent mental capacity assessors to ensure the decision being made regarding the patient who could not decide themselves, was in the patient's best interest.

All clinical staff had received training in the MCA within the last 12 months. However, reception staff had not yet received MCA training. The practice manager told us that this was being reviewed.

Health Promotion and Prevention

There were regular appointments offered to patients with complex illnesses and diseases. The practice manager explained that this was so that patients could access care at a time convenient to them. Screening tests were offered for mammography screening and diseases such as cancer.

Vaccination clinics were organised on a regular basis which were monitored to ensure those that needed vaccinations were offered. Patients were encouraged to adopt healthy lifestyles and were supported by services such as gym referrals, weight management or smoking cessation clinics. Patients with diabetes were invited to a diabetes clinic where staff discussed how changes to lifestyle, diet and weight could influence their diabetes.

All patients with learning disability were offered a physical health check each year. There had been a 70% take up of these invitations for a health check in the last 12 months. The practice worked closely with learning disability nurses to explain the benefits of these health checks.

Staff explained that when patients were seen for routine appointments, prompts appeared on the computer system to remind staff to carry out regular screening, recommend lifestyle changes, and promote health improvements which might reduce dependency on healthcare services.

The diabetic appointments supported and treated patients with diabetes which included education for patients to learn how to manage their diabetes through the use of insulin. Health education was provided on healthy diet and life style.

There was a range of leaflets and information documents available for patients within the practice and on the website. These included information on family health, travel advice, long term conditions and minor illnesses. Website links were easy to locate. Easy to read leaflets were available.

Good

Are services effective?

(for example, treatment is effective)

Family planning, contraception and sexual health screening was provided at the practice.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients told us they felt well looked after at the practice. QOF data showed that 95.7% of patients here would recommend their practice, which is higher than the English national average of 79%. The Kernow CCG average is 84%.

GPs told us they always made the effort to speak with their patients and treat them with respect. The 2014 GP Patient survey of the practice had received replies from 138 respondents. 100% had confidence and trust in the last GP they saw or spoke to. 95% found the receptionists at this practice helpful. Both of these are higher than the CCG average.

Patients told us they felt they were communicated with in a caring and respectful manner by all staff. Patients spoke highly of the staff and GPs. We did not receive any negative comments about the care patients received or about the staff.

We left comment cards at the practice for patients to tell us about the care and treatment they received. We collected 34 completed cards which contained overwhelmingly positive comments. All comment cards stated that patients were grateful for the caring attitude of the staff who took time to listen effectively.

Patients were not discriminated against and told us staff had been sensitive when discussing personal issues.

We saw that patient confidentiality was respected within the practice. The waiting areas had sufficient seating and were located away from the main reception desk which reduced the opportunity for conversations between reception staff and patients to be overheard. There were additional areas available should patients want to speak confidentially away from the reception area. We heard, throughout the day, the reception staff communicating pleasantly and respectfully with patients.

Conversations between patients and clinical staff were confidential and conducted behind a closed door. Window blinds, sheets and curtains were used to ensure patient's privacy. The GP partners' consultation rooms were also fitted with dignity curtains to maintain privacy.

Care planning and involvement in decisions about care and treatment

Patients told us that they were involved in their care and treatment and referred to an ongoing dialogue of choices and options. Comment cards related patients' confidence in the involvement, advice and care from staff and their medical knowledge, the continuity of care, not being rushed at appointments and being pleased with the referrals and ongoing care arranged by practice staff.

We were given specific examples where the GPs and nurses had taken extra time and care to involve patients in their own care and treatment. For example, GPs at the practice had created a large number of different leaflets explaining various medical procedures or conditions for patients. These were based on National Institute for Health and Care Excellence (NICE) guidance and met best practice. GPs had liaised with learning disability nurses to prepare easy to read leaflets to involve patients in their own 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, 96% of respondents say the last GP or nurse they saw or spoke to was good at giving them enough time for their treatment. This is higher than the Kernow CCG average of 95%. The patients we spoke to and the comment cards we received were consistent with this information.

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

Staff told us families who had suffered bereavement were contacted by their usual GP. GPs said the personal list they held helped with this communication. There was a counselling service available for patients to access.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us they felt the staff at the practice were responsive to their individual needs. They told us that they felt confident the practice would meet their needs. GPs told us that when home visits were needed, they were normally made by the GP who was most familiar with the patient.

Systems were in place to ensure any referrals, including urgent referrals for hospital care and routine health screening including cervical screening, were made in a timely way. Patients told us that any referral to secondary care had always been discussed with them.

An effective process was in place for managing blood and test results from investigations. When GPs were on holiday the other GPs covered for each other and results were reviewed within 24 hours, or 48 hours if test results were routine. Patients said they had not experienced delays receiving test results.

A patient representation group (PRG) had been set up. Membership was composed of a range of patients from different population groups at the practice. We spoke with a member of this group. They told us that the practice encouraged them to contribute suggestions and acted upon them.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. Staff said no patient would be turned away.

The number of patients with a first language other than English in Lostwithiel was very low, although the exact figure was unknown. The practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

The patient participation group was working to recruit patients from different backgrounds to reflect the diversity of the practice.

General access to the building was good. The practice had an open waiting area and sufficient seating. The reception and waiting area had sufficient space for wheelchair users. Consulting rooms had level access. Patient waiting areas, consultation and treatment rooms were based on the ground floor.

There was no evidence of discrimination when making care and treatment decisions.

Access to the service

Telephone access to the service was good. 94% of patients stated in the GP Patient Survey that it was easy to get through on the telephone. This is significantly higher than the Kernow CCG average of 82%.

Patients were able to access the service in a way that was convenient for them and said they were happy with the system. Of the 34 comment cards we received, one mentioned that it was sometimes difficult to get an advance booked appointment with their preferred GP. However, all other comments, discussions and feedback indicated that patients were happy with the arrangements for access to the service.

The GPs provided a personal patient list system. These lists were covered by colleagues when GPs were absent. Patients appreciated this continuity and GPs stated it helped with communication.

84% of the 138 respondents of the 2014 GP Patient survey stated that they could usually get to see or speak to their named GP. This is significantly higher than the Kernow CCG average of 66%. These findings were reflected during our conversations. Patients were happy with the appointment system and said they could get a same day appointment if necessary.

Information about the appointment times were found on the practice website and on notices at the practice. Patients were informed about the out of hours arrangements by a poster displayed in the practice, on the website and on the telephone answering message.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The nominated member of the staff at the practice who dealt with complaints is the practice manager.

Patients told us they had no complaints and could not imagine needing to complain. Not all patients were aware of how to make a complaint but said they felt confident that any issues would be managed well.

The posters displayed in the waiting room and patient information leaflet explained how patients could make a complaint. The practice website also stated that the practice welcomed patient opinion by sharing ideas, suggestions, views and any concerns.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The complaints procedure stated that complaints were handled and investigated by the practice manager and would initially be responded to within three days. Records were kept of complaints which showed that patients had been offered the chance to take any complaints further, for example to the parliamentary ombudsman.

Staff were able to describe what learning had taken place following a complaint. Complaints were also discussed as a standing agenda item at the clinical meetings held every six weeks and any shared learning took place.

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 vision was communicated to all staff via regular meetings. The vision was to be the best practice they possibly can be, and to give the best local service possible to patients. The practice commitment statement had been updated in 2014 and was kept under regular review.

Staff knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff spoke positively about communication, team work and their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work. There was a stable staff group and many staff had worked at the practice for many years and were positive about the open culture.

We were told there was mutual respect shared between staff of all grades and skills and that they appreciated the non-hierarchical approach and team work at the practice.

Staff said the practice was small enough to communicate informally through day to day events and more formally though meetings and formal staff appraisal.

Governance Arrangements

Staff were familiar with the governance arrangements in place at the practice and said that systems used were both informal and formal. Issues were discussed amongst staff as they arose, for example, staff cover for sickness and annual leave.

GPs met daily and discussed any complex issues, workload or significant events or complaints. These were often addressed immediately and communicated through a process of face to face discussions or email. These issues were then followed up more formally at six weekly clinical meetings where standing agenda items included significant events, near misses, complaints and health and safety. Staff explained these meetings were well structured, well attended and a safe place to share what had gone wrong.

The practice used the quality and outcomes framework (QOF) to assess quality of care as part of the clinical governance programme. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their GP practices.

Every year since 2004 the practice has improved its QOF performance. QOF points are grouped in categories such as diabetes, dementia and heart conditions. The QOF scores for Lostwithiel were above the Kernow CCG average.

The clinical auditing system used by the GPs assisted in driving improvement. All GPs were able to share examples of audits they had performed. Examples of audits included dementia patient audits, impotence medicines audits, stomach issues audits, Parkinson's disease audits and significant event audits.

The examples of audit we looked at followed a complete audit cycle of audit, action, and re-audit. Audits were readily available to provide a resource for trainees and other staff.

Leadership, openness and transparency

Staff were familiar with the leadership structure, which had named members of staff in lead roles. For example, there was a lead nurse for infection control, and a lead GP for safeguarding. Staff spoke about effective team working, clear roles and responsibilities and talked about a supportive non-hierarchical organisation. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff described an open culture within the practice and opportunities to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. Staff were aware of where to find these policies if required.

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

Patients we spoke with in the waiting room had not been formally asked for their views about the practice but they were aware there were suggestion boxes in the waiting room. The website signposted patients to give feedback if they chose.

The practice had a patient participation group (PPG). We spoke with a member of this group. They told us that the practice had responded positively to feedback and put in place suggested actions. These included a doorbell at the front door, as some patients found it heavy to open. The

Are services well-led?

Good

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

provision of antiseptic hand gel at reception had also been suggested and acted upon. The PPG member said they were encouraged to contribute suggestions by the practice management.

Management lead through learning & improvement

A process was followed so that learning and improvement could take place when events occurred or new information was provided. For example, a GP at the practice had given a presentation on dementia care to all staff in October 2014. The same GP had completed a research project on the same topic in 2013 which led to their nomination for achievement by the British Medical Journal. The GP had also given the same presentation at other venues to wider audiences. The practice held six monthly staff meetings to discuss any current topics and review any newly released national guidelines and the impact for patients. There was formal protected time set aside for continuous professional development for staff and access to further education and training as needed.

There were environmental risk assessments for the building. For example annual fire assessments, electrical equipment checks, control of substances hazardous to health (COSHH) assessments and visual checks of the building had been carried out. Health and safety items were a standing agenda item for the six weekly clinical meetings.

One of the GPs at the practice had organised a local young GPs support group. This group provided up to date learning and improvement for GPs through a range of different guest speakers. This included specialists and consultants who also made themselves available for one to one question and answer sessions for GPs.