Tideswell Surgery

Quality Report

The New Surgery
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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?	Outstanding
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this practice on 16 October 2014 as part of our new comprehensive inspection programme. This is the first time we have inspected this practice.

This practice has an overall rating of good and it was providing good quality care and treatment across all domains and population groups. We saw some examples of outstanding care.

- Patients told us they were satisfied with the appointments system and told us it met their needs.
- Patients were kept safe from the risk and spread of infection as the provider had carried out audits and acted on their findings
- Patients were treated with dignity and respect and spoken to in a friendly manner by all staff
- Systems were in place to keep patients safe by assessing risk and taking steps to reduce this. We saw evidence of learning from previous incidents.
- Patients, their relatives and carers were involved in all aspects of treatment and their opinions were listened to and acted upon.

We saw examples of outstanding practice. The practice is situated in a remote rural location with a dispersed patient group and limited access to public transport. We saw that action had been taken to ensure patients received the care they required, for example;

- The practice offered branch surgery sessions in three nearby villages to ensure all patients could access the service they required. Surgeries were held in village halls where patients could have simple health checks, consultations and request and collect prescriptions. Any more serious concerns could be dealt with at the main practice. Patients told us the valued this service and found it invaluable
- The lead GP carried out research into rates of depression and poor mental health amongst the rural community of North Derbyshire. Isolation and depression was identified as a major factor in rural communities. This led to the Farm out Project being

Summary of findings

developed to provide social and wellbeing activities for the local farming community. The project had proved very successful and was implemented across the CCG area

- The practice had developed health and lifestyle checks specifically designed for teenagers. This looked at vaccination status, physical health checks and lifestyle advice. It has proved so successful it has been rolled out across the Clinical Commissioning Group area.

However, there were areas of practice where the provider should make improvements.

The provider should:

- Ensure that audit cycles are completed by carrying out a second review of the subject
- The provider should ensure that curtains or screens are fitted in treatment rooms to further protect patients dignity

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for 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 accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding

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

Patients told us it was easy to get an appointment with a named GP or a GP of choice, with continuity of care and urgent appointments available the same day. The practice had good facilities and was

Summary of findings

well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

The practice offered branch surgery sessions in three nearby villages to ensure all patients could access the service they required. Surgeries were held in village halls where patients could have simple health checks, consultations and request and collect prescriptions. Any more serious concerns could be dealt with at the main practice. Patients told us the valued this service and found it invaluable

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and it had a very active patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the 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.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were high for all standard childhood immunisations with 100% of registered children receiving all immunisations by age five. 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, school nurses and the local school. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

The practice had developed health and lifestyle checks specifically designed for teenagers. This looked at vaccination status, physical health checks and lifestyle advice. It has proved so successful it has been rolled out across the Clinical Commissioning Group area.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice 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

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and 100% of these patients had received a follow-up. It offered longer appointments, with the same staff for continuity of care for people with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

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

An example of good practice was that the lead GP carried out research into rates of depression and poor mental health amongst the rural community of North Derbyshire. Isolation and depression was identified as a major factor in rural communities. This led to the Farm out Project being developed to provide social and wellbeing activities for the local farming community.

Everybody registered with mental health needs had 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.

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND, SANE and the Farm Out Project. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We received 23 comments cards from patients who used Tideswell Surgery; all of these contained positive comments. Patients were happy with the care and treatment they received and felt they were treated with dignity and respect by all staff.

Additionally we spoke with five patients on the day of our inspection. All five told us they were able to access appointments when required, they felt they were involved in discussions about their care and were able to make informed decisions.

Patient surveys carried out by the practice in 2013 showed that patients were overwhelmingly happy with the service provided and felt informed and involved with their care. For example, all the patients who responded stated they were happy with the care and treatment they received and felt they were treated with dignity and respect by the practice. Analysis of the 2014 national GP patient survey by NHS North Derbyshire showed that the practice had very high levels of patient satisfaction for all areas of the service.

Areas for improvement

Action the service SHOULD take to improve

- The provider should ensure that curtains or screens are fitted in treatment rooms to further protect patients dignity
- The provider should ensure that audit cycles are completed by carrying out a second audit of the subject

Outstanding practice

We saw examples of outstanding practice. The practice is situated in a remote rural location with a dispersed patient group and limited access to public transport. We saw that action had been taken to ensure patients received the care they required, for example;

- The practice offered branch surgery sessions in three nearby villages to ensure all patients could access the service they required. Surgeries were held in village halls where patients could have routine health checks, consultations and request and collect prescriptions. Any more serious concern could be dealt with at the main practice.
- The lead GP carried out research into rates of depression and poor mental health amongst the rural community of North Derbyshire. Isolation and depression was identified as a major factor in rural communities. This led to the Farm out Project being developed to provide social and wellbeing activities for the local farming community

The practice had developed health and lifestyle checks specifically designed for teenagers. This looked at vaccination status, physical health checks and lifestyle advice. It has proved so successful it has been rolled out across the Clinical Commissioning Group area.

Tideswell Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a practice manager and an expert by experience.

Background to Tideswell Surgery

Tideswell Surgery is a rural dispensing practice based in the Derbyshire village of Tideswell. The practice has approximately 3340 registered patients, the majority of whom are over the age of 65.

Parking for patients and staff is available at the practice and the building has single level access to aid people with reduced mobility, wheelchair users and parents/carers with pushchairs.

The practice staff consists of a male lead GP, and two female salaried GPs, six reception staff (who are also qualified to work in the dispensary), one female practice nurse, a nurse practitioner one phlebotomist (a staff member trained and skilled to taking blood samples), a practice manager and assistant practice manager. A pharmacy technician, team leader and senior reception manager were also employed at the practice.

The practice does not provide its own out-of-hours service but arrangements are in place for patients to be seen by Derbyshire Health United, when the practice is closed.

Why we carried out this inspection

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

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

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

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

How we carried out this inspection

Prior to our inspection we reviewed information about the practice and asked other organisations to share what they knew about the service.

We carried out an announced comprehensive inspection of this practice on 16 October 2014.

During our visit we spoke with a range of staff (including three GPs, a nurse, a community matron, the practice manager and three administrative and reception staff). We spoke with four patients who used the service, and members of the patient participation group (PPG). The

Detailed findings

patient participation group are a group of patients who work together with the practice staff. They represent the interests and views of patients with the aim of improving the service being provided. We reviewed 23 comment cards where patients and members of the public 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. These groups are:

Older people

People with long-term conditions

Families, children and young people

Working age people (including those recently retired and students)

People whose circumstances may make them vulnerable

People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice 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.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last three years. The practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last three years and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held regularly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff all knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms available on the practice intranet and sent completed forms to the practice manager. The practice manager showed us the system she used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action that had been taken as a result of incidents that were raised. For example, we saw investigation of an incident which included an action plan; reflection on lessons learnt and resulted in change to standard operating procedures. We also saw that additional training had been delivered for all staff following the incident. 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 all 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 team meetings to help ensure all staff were made aware of any that were relevant to the practice area in which they worked, also where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. All of the staff we spoke with confirmed they had received training appropriate to their role and knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and understood how to share information, document safeguarding concerns and how to contact the relevant agencies both in working hours and out of normal hours. We saw contact details were easily accessible at key points in the practice.

The practice had appointed dedicated GPs' as leads in safeguarding vulnerable adults and children. They had been trained to Level 3 and could demonstrate they had the necessary training to enable them to fulfil this role (eg level 3). All staff we spoke to were aware who these lead was and who to speak to in the practice if they had a safeguarding concern.

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

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All nursing staff, had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, all seven reception staff had also undertaken training and understood their

responsibilities when acting as chaperones, including where to stand to be able to observe the examination. None of the reception staff we spoke with had ever had to act as chaperone.

GPs were appropriately using the required codes on their electronic case management system to ensure that vulnerable patients were clearly flagged and reviewed. We saw that vulnerable patients and those with several on going conditions regularly had their medication and treatment reviewed.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed 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.

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

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an Independent Nurse Prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We checked anonymised patient records which confirmed that the procedure was being followed.

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

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

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.

Records showed that all members of staff involved in the dispensing process had received appropriate training, achieving at least Level 2 NVQ and their competence had been checked regularly.

The practice had established a service for people to pick up their dispensed prescriptions at several locations and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that people collecting medicines from these locations were given all the relevant information they required. For example medicine safety leaflet and patient information leaflets.

Cleanliness and infection control

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

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 carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, correct hand washing technique and disposal of hazardous waste. There was also a policy for needle stick injury.

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. A practice training day identified that not all staff were aware of the correct hand washing technique. Additional training was offered by the practice nurse. Additionally the infection control lead nurse for the Clinical Commissioning Group (CCG) was invited to the practice to give advice.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). 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. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometer for the last two years. In the week prior to our inspection all medical equipment had been recalibrated. As a consequence, at the time of our inspection the certificate of calibration was not available.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

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. We noted that many staff had dual roles i.e. receptionist / dispenser. Staff told us this helped ensure all shifts were covered and that they welcomed the diversity of duties and acquiring new skills. 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 all new staff had successfully completed an induction training package. Staff we spoke to told us they found this helpful and felt the training had given them a good insight into the running of the practice. We saw that an l information pack had been developed to assist locum GPs who may work at the practice.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management,

staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at clinical meetings and within team meetings. For example, the practice manager regularly shared the findings from significant events or reviews of practice, including audits.

The practice had developed care plans for the top 2% of the practice population at risk of requiring emergency or out-of-hours care. This included people with long term conditions, dementia, mental health concerns or people on end of life care pathways. The plans included an emergency telephone number for those specific patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this appropriately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check 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 power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

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

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this for ensuring staff were able to travel to the practice during bad weather, and the mitigating actions that had been put in place to manage this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurse we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. 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 nurse 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 osteoporosis, mental health, diabetes, heart disease and asthma. The community matron and practice nurse supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of a range of conditions such as diabetes and respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice had signed up to the Unplanned Admission Direct Enhanced Service with the CCG. This is a system whereby those patients most at risk of hospital admission have additional support and monitoring from the practice. The aim is to reduce unplanned hospital admissions by active management of care from the practice.

Prior to the inspection we saw data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic and statin prescribing which was better than the average for similar practices in the area. The practice had also completed a review of prescribing of Proton Pump Inhibitors (PPIs), medicines used to treat gastro intestinal problems, along with prescribing of oral contraceptive. The review of contraceptive prescribing resulted in GPs ensuring all newly prescribed patients had a record of the blood pressure taken which was then repeated at the next medicine review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of cancer under the two week target. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

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

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 and community matron to support the practice to carry out clinical audits.

The practice showed us four clinical audits that had been undertaken in the last two years. Although none of these were completed audits, as the second cycle was not completed, the practice was able to demonstrate they had instigated changes as a result of the initial review. For example a review of oral contraceptive prescribing identified the patient's Body Mass Index was not routinely noted. This measurement was added to the consultation. Other examples included reviews of diabetes care, missed outpatient appointments and treatment of chronic obstructive pulmonary disease (COPD).

The GPs told us clinical reviews 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 national performance measurement tool. For example, we saw an audit regarding the prescribing of anti-coagulant medicines to patients with Atrial Fibrillation (AF) a condition affecting the heart.

Good

Are services effective?

(for example, treatment is effective)

During and following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, over 95% of patients with diabetes had an annual medication review. The practice had met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease).

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit, review and quality improvement. Staff acknowledged that they needed to increase the number of completed audit cycles by ensuring a second audit was completed. We noted that additional training had been requested to address this.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving 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. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, they outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice dispensary staff had worked with the CCG (Clinical Commissioning Group) Medicines Management Team to develop and Gluten Free Formulary (a directory of medicines that did not contain any gluten or gluten containing ingredients that would be safe for patients with coeliac disease to take). This had ensured equitable, cost effective and appropriate prescribing for patients with Coeliac disease. The formulary proved very successful and is now included in the main formulary for the CCG.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, All of the patients requiring palliative care were recorded on the register.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to and in the majority of incidences better than other services in the area. For example monitoring of risk of heart disease, review of care of cancer patients and health checks for patients with COPD.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors. All GPs 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 staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example the community matron had been supported and funded to achieve a diploma in treatment of diabetes, COPD, asthma, non-medical prescribing and physical health assessment.

The practice nurse and nurse practitioner were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles, for example carrying out health checks for patients with long term conditions, were also able to

demonstrate that they had appropriate training to fulfil these roles. We saw that the assistant practitioner (also known as a nurse practitioner) had been supported and funded by the practice to achieve a foundation degree as assistant practitioner.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and support people 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 staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately. The practice recorded a significant event when a patient had been discharged from hospital and the practice was not informed for ten days. The lead GP contacted the hospital to express concern and gather information. The issue was passed to the CCG for further investigation. At the time of our inspection the results of the investigation had not been shared with the practice, however we received assurances that the practice would follow this up.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs, mental health concerns or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses, community matron, community psychiatric nurse and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

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 that information relating to patients was only shared with their prior consent. Electronic systems were also in place for making referrals, and the practice made referrals last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system 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. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke to understood the

Good

Are services effective?

(for example, treatment is effective)

key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had a written policy to help staff, for example with making do not attempt resuscitation orders. 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 learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population.

Annual health checks were offered for patients with learning disabilities, patients over 75, those with long term conditions and patients with mental health concerns or dementia. The GP was informed by the practice nurse of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and these were offered an annual physical health check. Practice records showed all had received a check up in the last 12 months. The practice had also offered nurse-led smoking cessation clinics to patients. There was evidence these had some success, as the number of patients who had stopped smoking in the last 12 months had increased. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 82.5%, which was broadly similar to other practices in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. The community matron was responsible for following up patients who did not attend screening. Performance for chlamydia, mammography and bowel cancer screening in the area practice were around average for the CCG, and a similar mechanism of following up patients who did not attend was also used for screening programmes.

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 CCG, with all registered children receiving all immunisations by the age of five. Again there was a clear policy for following up non-attenders by the named practice nurse.

An example of outstanding practice was identified whereby the practice had developed health and lifestyle checks specifically designed for teenagers. This looked at vaccination status, physical health checks and lifestyle advice. It has proved so successful it has been rolled out across the CCG area.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 national patient survey, and a survey of 97 patients undertaken by the practice's patient participation group (PPG). The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses with 95% of practice respondents saying the GP was good at listening to them and 98% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 23 completed cards and all were positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with five 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 not available in all consulting rooms and treatment rooms so that patients' privacy and dignity was not always maintained during examinations, investigations and treatments. We asked the practice to ensure curtains or screens were available. Following our inspection we received confirmation that new curtains had been purchased. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. There was evidence of learning taking place as staff meeting minutes showed this has been discussed.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 90% of practice respondents said the GP involved them in care decisions and 95% felt the GP was good at explaining treatment and results. Both these results were well above the CCG and national averages.

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

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

Patient/carer support to cope emotionally with care and treatment

The 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, patients we spoke to on the day of our inspection said they had

Good

Are services caring?

received help to access support services to help them manage their treatment and care when it had been needed. Comment cards we received confirmed this. For example, they highlighted that staff responded compassionately when they needed help and provided support when required.

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

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. We saw that a home visit was carried out by the GP to the bereaved person to offer additional support.

Outstanding ☆

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 people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice offered branch surgery sessions in three nearby villages to ensure all patients could access the service they required. This meant that services were more accessible to patients as they were not required to travel to the main surgery from outlying villages. Surgeries were held in village halls where patients could have simple health checks, consultations and request and collect prescriptions. Any more serious concerns could be dealt with at the main practice.

The NHS Area Team (AT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

The practice was aware of the difficulty experienced by its patients in accessing services at hospitals due to the rural location and lack of public transport. The practice had worked with the AT and CCG to provide services at the surgery building to enable ease of access. For example, the lead GP had completed an audit of missed appointments, (sometimes called Did Not Attend (DNA)) for physiotherapy appointments at the local hospital. The audit showed that the main reason for DNA by practice patients was lack of transport.

The practice hosted a physiotherapy service which was commissioned by the CCG. We saw that the waiting time for a physiotherapy appointment was two weeks, significantly lower than for the hospital based service, and that patients very much valued the service.

Additionally the practice had identified that patients experiencing poor mental health struggled to access services. The practice worked with the CCG to provide cognitive behavioural therapy and counselling sessions. Again the wait to access these appointments was significantly shorter than for the hospital based service.

Other services offered in partnership with the CCG included, podiatry, midwifery and health visitor. The practice was also the base for a citizen's advice drop in session.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). We spoke with members of the PPG who told us they worked well in partnership with practice staff and felt they were listened to. They told us they had been asked for input on a range of issues including the purchase and content of (a digital information display system, the new appointment system and the choice of décor for the practice.

We saw that all staff had undertaken training on the Mental Capacity Act 2005 (MCA) and were understanding of the requirements of people experiencing poor mental health. The lead GP had worked with Derbyshire Dales District Council, the CCG and other providers and carried out research into rates of depression and poor mental health amongst the rural community of North Derbyshire. This led to the Farm out Project being developed to provide social and wellbeing activities for the local farming community. Isolation and depression was identified as a major factor in rural communities. The project had proved very successful and was implemented across the CCG area to include psychological and physical health drop in sessions along with advice on family farm safety.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

We saw that patients with learning disabilities were given longer appointment times and, where possible, saw the same GP or nurse to ensure continuity of care.

The practice had access to online and telephone translation services.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of people with disabilities and those with reduced mobility. All treatment and consulting rooms were on the ground floor of the building, there was level access and accessible toilets. A disabled parking space had been marked out in the car park.

All of the patients registered at the practice spoke English as their first language, although it could cater for other languages through translation services.

Access to the service

Appointments were available Monday to Friday from 8 am to 6pm on weekdays. Every alternate Monday and Thursday the practice was open 6:30pm to 8pm. On Tuesday mornings the practice opened at 7:30am. The practice had 'open access' appointments available every weekday morning whereby patients could walk in and request an appointment straight away.The practice has pre bookable appointments between 9am and 10am every weekday morning, as well as open access appointments 10am-11am each weekday morning. Telephone consultations were also offered.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments via telephone. 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. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one.

Patients told us were very satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. The GP Patient survey data for 2014 showed that 96% of patients described their experiences of making an appointment as good and 84% of patients were able to see the GP of their choice. Both these figures were significantly higher than the local and national averages. We saw an example of a patient who was holidaying in the area and had been seen as an emergency appointment straight away. The patient had sent a thank you letter praising the staff and service.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system via the practice leaflet and information displayed in the waiting area. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at two complaints received in the last 12 months and found they were handled in a timely way and in line with the practice complaints policy. Both complaints showed evidence of thorough investigation involving several members of staff and appeared to have been resolved to the complainant's satisfaction.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Staff we spoke with told us that any learning from complaints was discussed at team meetings and were necessary, changes to practice were implemented.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and long term business plan. These values were clearly embedded in everything the practice did. The practice vision and values included offering excellent access of service to the whole community and providing excellent care from friendly and well trained staff.

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

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at some of these policies and procedures and saw that all staff had signed to confirm that they had read the policy and when. All policies and procedures we looked at had been reviewed annually and were up to date.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in significantly above national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, we saw an audit regarding the prescribing of anti-coagulant medicines to patients with Atrial Fibrillation (AF) a condition affecting the heart. During and following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as slips and trips and staff absence. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

The practice held monthly governance meetings. We looked at minutes from previous meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that training and development meetings were held for all staff every month.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment policy and complaints policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual patient survey which showed the majority of patients were happy with the care they received. The survey also identified that some patients were not aware they could order repeat prescriptions online and some were not aware of the full range of services offered at the practice. We saw that additional information on these was provided.

The practice had an active patient participation group (PPG) which has steadily increased in size. The PPG included representatives from various population groups. The PPG had carried out annual surveys and met every quarter. The practice manager showed us the analysis of

Are services well-led?

Good

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

the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website and via NHS Choices

The practice had gathered feedback from staff through staff meetings, appraisal and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff we spoke with told us they were able to ask for additional training to enhance their role and it was provided. We saw that training was funded for all dispensary staff to achieve level 2 NVQ in dispensing. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended. For example when an infection control audit highlighted an issue, the infection control lead nurse for the CCG attended the staff meeting. Other invited experts included safeguarding leads and other staff from the CCG.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. We saw that the practice included examples of good practice along with any concerns as significant events. For example prescribing errors or failure of a hospital to inform the practice a patient had been discharged.