Balmore Park Surgery

Quality Report

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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Balmore Park Surgery is located in a purpose built medical centre in the Caversham area of Reading. There is a commercial pharmacy located in the practice premises. Approximately 16,000 patients are registered at the practice. We carried out an announced comprehensive inspection of the practice on 4 November 2014. This was the first inspection of the practice since registration with the CQC.

Patients we spoke with were positive about the care they received and described the staff as caring. The practice results for the national GP patient survey 2013 were positive and compared well with the clinical commissioning group (CCG) and national average. Ninety seven per cent of patients said they would recommend the practice to others.

We spoke with eight patients during the inspection. We met with two members of the patient participation group and spoke with seven GPs and a range of practice staff.

Balmore Park Surgery was rated good overall.

Our key findings were as follows:

- medicines are managed safely in a clean and well kept environment.
- GPs treat patients in accordance with national and local guidelines. Staff are trained and knowledgeable. The practice works with other services to ensure patients with complex needs are cared for appropriately. District nurses and health visitors told us there are good working arrangements with the GPs.
- patients told us and we observed that they were treated with care and compassion. Staff were careful to maintain confidentiality of patient information.
- the practice offers a range of appointment options and alternative means of booking appointments, including online booking. Patients receive continuity of care from a named GP and arrangements are in place to meet patients' needs when GPs are not on duty.
- the practice is well led. Staff show a strong commitment to delivering patient centred care in a timely manner.

Summary of findings

- extended hours clinics are available on four evenings a week and every other Saturday. From 8 November clinics would be held every Saturday
- the practice added a pulse check to the blood pressure check for patients with high blood pressure. This led to early diagnosis of an abnormal heart rhythm for some patients who were then treated promptly for this condition.

We saw an area of outstanding practice this was:

- the practice worked with local health commissioners to provide a wide range of additional services. Including ultrasound, dermatology clinics, podiatry, physiotherapy and talking therapies. All providing local access for the practice patients and reducing the need for travel or attendance at hospital.

However, there were also areas of practice where the provider needs to make improvements.

The provider should:

- increase the take up of health checks for patients with a learning disability

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 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 patients safe. The environment and equipment were maintained to support patient safety.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were above average for the locality. National Institute for Health and Care Excellence (NICE) guidance were readily available and used routinely. The practice was proactive in managing patients identified with the likelihood of developing diabetes. The same clinical guidelines were used in the care and treatment of these patients as those already diagnosed with diabetes. Additional checks had been included for patients with high blood pressure to identify of irregular heart rhythm and commence early treatment. The practice was able to identify appraisals for all staff. Working closely with other health professionals was evidenced. The district nurses we spoke with told us co-ordinating patient care with the practice worked well. Clinical audits were undertaken on a regular basis and results from those audits were used to improve the quality of services provided. There were staff with the right skills and experience who were developed in their role.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care and patients we spoke with on the day gave similar views. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Outstanding

The practice is rated outstanding for being responsive to patient's needs. A wide range of appointment types and times were available. These included four evenings and every other Saturday. Saturday clinics were increasing from 8 November and included on the day appointments. Some GPs had changed the days they worked in the

Summary of findings

past to offer more appointments on days when demand was high. A wide range of services including physiotherapy and ultrasound were available at the practice to help patients avoid trips to hospital and clinics elsewhere. Patients reported good access to appointments, a named GP and continuity of care. Urgent appointments were available the same day. Referrals to other services were made in a timely manner and the urgency of processing a referral was clearly identified by a priority grading system. There was a clear complaints policy and procedure demonstrating that the practice responded quickly to issues raised and brought them to resolution. There was evidence of shared learning from complaints with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a philosophy of delivering good quality care in a timely manner and we found staff demonstrated commitment to this philosophy. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular management team meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and training events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older patients. The practice offered proactive, personalised care to meet the needs of this patient group and had a range of enhanced services, for example, in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs and home visits. Supporting patients to use Choose and Book to make referral appointments.

People with long term conditions

Good

The practice is rated as good for the population group of patients with long term conditions. Processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medicines needs were being met. Co- ordination of annual reviews for those patients with more than one long term condition was underway to avoid these patients attending the practice for separate reviews. Additional investigations were carried out for patients with high blood pressure and recording of the outcomes of annual reviews had been enhanced. 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 population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people identified where parents had been identified as requiring parenting support. Immunisation rates were meeting national targets for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Mother and baby health checks were offered to and taken up by all women who had given birth in 2013.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the 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 which reflected the needs of this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including carers and those with learning disabilities. The practice offered annual health checks for patients with learning disabilities. There were named GPs supporting patients with learning disabilities who lived in supported accommodation.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Eighty per cent of patients on the practice mental health register had received all of their physical health checks. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. A therapy service was available at the practice and GPs worked with other agencies in delivering shared care packages of care to patients with substance misuse problems.

Summary of findings

What people who use the service say

The results from the most recent national patient survey showed patients to be positive about the services they received from the practice. This was reflected by 97% of the 121 patients who responded saying they would recommend the practice. This was 12% above the local CCG average. Eighty six per cent of the patients who took part in the survey said they usually got to speak to their GP of choice. This was also well above the average score for the CCG.

The eight patients we spoke with during the inspection and most of the 42 patients who completed CQC comment cards prior to our visit were also positive about the care and treatment they received from the practice. Patients told us they were treated with dignity and respect and felt involved in planning their care and treatment needs. They also told us that GPs were caring and gave good explanations of the treatment proposed or underway.

Areas for improvement

Action the service SHOULD take to improve

- increase the take up of health checks for patients with a learning disability

Outstanding practice

- the practice worked with local health commissioners to provide a wide range of additional services.

Including ultrasound, dermatology clinics, podiatry, physiotherapy and talking therapies. All providing local access for the practice patients and reducing the need for travel or attendance at hospital.

Balmore Park 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 and an expert by experience. Experts by experience are members of the team who have received care and experienced treatment from similar services.

Background to Balmore Park Surgery

Balmore Park Surgery is located in the Caversham area of Reading. The practice premises are purpose built and also accommodate a commercial pharmacy.

There are approximately 16,000 patients registered with the practice. The practice has a larger number of patients aged 30 to 49 than other practices in the local area and nationally. The number of patients over the age of 65 is similar to the national average. There are 7 partners and four salaried GPs at the practice. Some of the seven female and five male GPs do not work every day of the week. The practice is accredited to provide training for GPs and one GP in training was in post at the time of inspection. The practice is awaiting confirmation to train a second GP. The practice employs seven practice nurses, a health care assistant and a phlebotomist. The practice manager is supported by a team of administrative and reception staff. Services are provided via a personal medical services (PMS) contract held with the local team of NHS England.

Information available to the CQC showed the practice performed well in delivering the targets contained in the Quality and Outcomes Framework (QOF). The QOF is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The practice takes part in enhanced services for example, extended surgery hours are offered four evenings each week and every other Saturday.

Services are provided from:

Balmore Park Surgery, 59a Hemdean Road, Caversham, Reading, Berkshire, RG4 7SS

The practice has opted out of providing out of hours services to their patients. There are arrangements in place for services to be provided when the surgery is closed and these are displayed at the practice, in the practice information leaflet and on the website.

Why we carried out this inspection

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

We carried out this comprehensive inspection of the practice, on 4 November 2014, 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. The practice had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from

Detailed findings

local organisations such as NHS England, Healthwatch and the North and West Reading Clinical Commissioning Group (CCG). We carried out an announced inspection visit on 4 November 2014. During our inspection we spoke with a range of staff, including GPs, practice nurses, the practice manager, a health care assistant (HCA) and reception and administration staff. We also spoke with health visitors and district nurses who worked closely with the practice GPs and nurses.

We observed how patients were being cared for and talked with eight patients and reviewed personal care or treatment records. We reviewed 42 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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

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

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

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

The percentage of the practice population who were over 65 was similar to other practices within the clinical commissioning group. The number of patients aged between 35 and 49, those of working age, was higher than the other practices in the locality as was the number of young children under the age of ten.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients.

We reviewed incident reports and minutes of meetings for the last year where these were discussed. This showed the practice had managed these consistently.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last year and these were made available to us. A formal review of significant events was conducted every quarter. Records showed the practice met the local target for reviewing an agreed number of significant events every year. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. We reviewed all the incidents for the last year and the records were completed in a comprehensive manner. Evidence of action taken as a result was shown to us. For example, GPs used the patient record number when dictating a letter to avoid letters being sent to the wrong patient when two patients had the same name.

National patient safety alerts were disseminated via the senior practice nurse. Medicine alerts were forwarded to GPs. GPs and nurses we spoke with confirmed that they received relevant alerts and took appropriate action. However, there was no system in place confirming actions had been completed.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young patients and adults. Practice training records showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. Staff knew where to find the contact details for the local authority safeguarding team and the safeguarding nurse specialist.

The practice had a dedicated GP appointed as lead in safeguarding. They were able to demonstrate they had the necessary training to enable them to fulfil this role. We found both GPs and nurses had received training to the highest level (level three) in safeguarding of children. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. GPs were appropriately using the required codes on their electronic patient record system to ensure risks to children and young patients who were looked after, or on child protection plans were clearly flagged and reviewed. A quarterly meeting was held with the health visitors to discuss all cases of concern relating to child safeguarding. The health visitors we met with told us these meetings were very useful and ensured information of concern was shared formally and documented. The practice had a system to highlight non-urgent concerns relating to care of younger children; for example, where parents had been identified as requiring support with parenting. When a case of this nature was highlighted it was passed to the child action team at the local borough council.

A chaperone policy was in place and visible on a noticeboard in the reception area. Chaperone training had been undertaken by nursing staff. The practice had made the decision not to train other staff in chaperone duties.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and only accessible to authorised staff. There was evidence of staff understanding the temperatures that medicines should be stored at. Records of temperature checks of medicines refrigerators showed them to be functioning within appropriate temperature ranges. Staff knew the appropriate action to take in the event of a refrigerator failure but this process was not contained in a written procedure or protocol.

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.

Good

Are services safe?

We saw records confirming the practice took part in local clinical commissioning group medicines management initiatives. These showed us the practice achieved 100% of the targets set locally for management of medicines.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support in their role as well as updating in the specific clinical areas of expertise for which they prescribed.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

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 saw an audit of one of these medicines which confirmed that the GPs reviewed administration of high risk medicines. The audit showed that GPs had recognised patients who had not received blood tests and had arranged for these patients to have the required tests.

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.

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 and we saw records confirming this had taken place.

The practice offered choice to patients relating to which pharmacy they used to dispense their medicines.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place. However cleaning records were not kept. We advised the practice manager of this finding. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice employed a housekeeper who undertook spot checks of the cleanliness of toilets during the working day and ensured they were clean.

The practice had a lead for infection control and we saw that nursing staff had undertaken further training to enable them to provide advice on the practice infection control policy. We saw evidence the lead had carried out a detailed infection control audit in the last year. The audit did not identify any improvements required.

The practice had a contract in place for the disposal of clinical waste. Clinical waste was appropriately segregated from general waste and suitable receptacles; for example, foot operated bins and sharps boxes were in place in the practice. However, the large bins of clinical waste awaiting collection by the contractors were not locked on the day of inspection. There was a very minor risk that clinical waste could be accessed by the public. We reported our finding to the practice manager who arranged for these bins to be locked.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. 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 in order to comply with the practice's infection control policy. Specimens received at the practice were taken by the patient to a collection point and did not require handling by staff. There were policies and procedures to deal with spillages of potentially dangerous fluids including bodily fluids.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a risk assessment relating to legionella (a germ found in the environment which can contaminate water systems in buildings) and other waterborne bacteria.

Good

Are services safe?

This had been completed by a qualified contractor only four weeks before our inspection. The report from the assessment had not been discussed in detail or an action plan formulated at the time of inspection. We were told this was an agenda item for a management team meeting in November 2014.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Nurses we spoke with told us they benefitted from having two spirometers (a spirometer measures the volume of air in and out of the lungs) to undertake Asthma and COPD (lung disease) tests. Tests could therefore, be undertaken both on a planned and opportunistic basis without having to wait for a machine to become available. They told us that all equipment was tested and maintained regularly and we saw invoices and certificates of maintenance 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.

The main services and important equipment installed within the practice were subject to appropriate servicing and maintenance arrangements. For example, there was a certificate confirming the gas system was safe and an invoice confirming the fire alarm system had been serviced, tested and passed fit to use.

Staffing and recruitment

Recruitment records we looked at contained references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. We spoke with staff who had been recruited in the last two years. They confirmed that photographic proof of their identity was checked prior to commencing work at the practice. However, copies of photographic proof of identity were not held on the files we reviewed. We discussed this with the practice manager. They made immediate arrangements to add copies of proof of identity to the personnel files. We were told this had been completed following our inspection. The practice had a recruitment policy that set out the standards it followed when recruiting GPs, nurses and administration staff.

There were duty rosters in place for all the different staffing groups to ensure there were enough staff on duty. The practice identified that more appointments were required and more phone calls requesting appointments received in the morning. We saw there were more staff working in the morning than in the afternoon to meet this demand. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. We saw records showing medical secretaries covered each other when on leave.

We saw that locum GPs were appropriately vetted before they started working at the practice. Nursing staff were required to produce evidence of membership of a professional body before they started work at the practice but there was not a system to check that professional registration had been maintained.

Monitoring safety and responding to risk

The practice had systems and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of medicines and emergency equipment. The practice also had a health and safety policy. Relevant health and safety information was displayed for staff to see.

Identified risks were discussed at practice meetings. For example, when patients who were referred from an optician for a blood pressure check and their blood pressure was raised, a protocol had been put in place to ensure the patients were followed up.

Support was given to patients referred to hospital who encountered problems in booking their appointments which could have resulted in them not receiving care and treatment. Staff assisted these patients to ensure the appointment was made. We were given examples of when this system supported older patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support and GPs had received training in advanced 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). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included

Good

Are services safe?

those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. 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. Risks identified included power failure, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, details of a heating company to contact in the event of failure of the heating system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. There were notices displayed prominently advising fire escape routes and the location where to gather in the event of a fire. Fire equipment was maintained in accordance with manufacturers' instructions. Regular fire drills were not undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance accessing 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 discussed. We found from our discussions with GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. The steps to follow when reviewing patients' care were included in templates on the computerised patient care record.

Patients with heart disease were given 15 minute appointments with the lead nurse responsible for reviewing this long term condition instead of the usual 10 for their medical reviews. GPs had decided that more time was needed to complete a thorough review of the care and treatment needs of this patient group. A GP had in the past identified that the electronic form used to enter information on the treatment of heart disease had a section missing which could have resulted in important information being missed. They added their own section to the form to ensure all treatment information was collected before the computer suppliers were able to rectify the problem. Patients identified with the potential to develop diabetes were subject to care planning using a similar protocol to that for patients already diagnosed with diabetes. Data showed the practice had a higher rate of early diagnosis of dementia than other practices in the clinical commissioning group. Early treatment and intervention was therefore, made possible. The practice was active in identifying and meeting the needs of patients who could develop a long term condition.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. GPs and nurses we spoke with were very open about asking for and providing colleagues with advice and support. For example, nurses told us they could access swift advice from GPs when patients presented with more complex needs than expected.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management.

The practice showed us 11 audits that had been undertaken in the last two years. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit Changes achieved resulting from clinical audit included ensuring patients taking a medicine requiring close monitoring (methotrexate) received regular blood tests and that patients having a coil fitted all gave written consent and received appropriate written information about the procedure. There were audits linked to medicines management. Data confirmed the practice had taken part in and achieved all the targets for medicines management set by the clinical commissioning group last year. For example, prescribing of cholesterol lowering medicines and anti-inflammatory medicines.

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, the practice met all the minimum standards for QOF in managing patients' asthma, chronic obstructive pulmonary disease (lung disease) and kidney disease.

Staff 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 the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. GPs told us how they ensured patients on repeat medicines received an annual review.

The practice also reviewed other performance data. For example, they were aware that fewer patients attended A&E or were admitted to hospital in an emergency from the practice. Active management of patients and education in using the appropriate service for non-urgent conditions was evident. The practice was working with a specialist nurse to identify and actively support patients with COPD (lung disease) who were at risk of hospital admission to reduce the risk of this happening. A rapid intervention and

Good

Are services effective?

(for example, treatment is effective)

reablement service was available in the area and the practice made appropriate referrals to this team to prevent unnecessary admission to hospital and support patients who were discharged from hospital.

There was a register of patients with a learning disability. Evidence showed this group of patients were invited to receive a full annual physical health check every year. We found just over 60% of these patients had received their check in 2014. We could not be reassured that all patients with a learning disability would receive their health check-up.

There had been a review of patients receiving end of life care. The review focussed on patients wishes being respected in regard to their preferred place of death and on ensuring information relating to the patient's needs were communicated to all relevant professionals. The review had been repeated after one year and showed all information had been communicated appropriately and that most patients who wished to die at home had been able to do so.

The practice had a system to identify additional health problems associated with high blood pressure. An additional check of the patients pulse had been added to the routine blood pressure check. This had resulted in early detection of Atrial Fibrillation (abnormal heart rhythm) in some patients.

Effective staffing

Practice staff included GPs, 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. Records showed GPs were trained to an advanced level in life support. A good skill mix was noted amongst the GPs with two having additional diplomas in sexual and reproductive medicine, and eight with diplomas in obstetrics and gynaecology. All GPs were up to date with their yearly continuing professional development requirements and all had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example, six practice nurses had completed additional training in control of infection during 2014. Staff we spoke with told us how they took part in, and valued, training provided by the local clinical commissioning group (CCG). We saw that a recent CCG training event had focussed on safeguarding and child protection. As the practice was a training practice, doctors who were in training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We found that two GPs who had trained at the practice had returned to work at the practice on a permanent basis once qualified.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. We noted that one nurse had been designated as lead for women's health and undertook all cervical cytology tests (cervical smears) to maintain quality. Another practice nurse led on services for patients with long term conditions such as asthma, COPD, diabetes and coronary heart disease. We spoke with this member of staff who gave us examples of how they had started co-ordinating the annual reviews for patients with more than one long term condition. We heard from GPs and other nursing staff that they wanted to extend this opportunity to more patients in similar circumstances.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received electronically. Urgent communication was received by fax. The practice had a protocol detailing the responsibilities of all relevant staff in passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. A member of staff we spoke detailed the process they followed to ensure information from other providers was passed to the relevant GP on the day it arrived at the practice. GPs we spoke with told us how they operated a 'buddy' system to ensure that results and letters were not left unanswered when they were not on duty.

Good

Are services effective?

(for example, treatment is effective)

The practice held multidisciplinary team meetings every four to six weeks to discuss the needs of patients with complex needs. This included those identified as requiring end of life care (as part of a national programme called the gold standards framework). The meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in the notes of the meeting that were circulated to all who attended. Staff we spoke with felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. The district nurses we spoke with described excellent liaison with GPs at the practice.

Information sharing

The practice used electronic and manual systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. There was evidence that the practice had a high level of reporting of changes in the needs of patients on end of life care packages to the local out of hours service. Electronic systems were also in place for making referrals, and the practice made all referrals last year through the Choose and Book system. (The Choose and Book system enabled patients to choose which hospital they wished to be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff we spoke with were knowledgeable in the use of this system and gave us examples of how they had supported some elderly patients to make their hospital appointments. We found that referrals for urgent treatment within two weeks were also processed through this system.

The practice had signed up to the electronic Summary Care Record and had plans to have this fully operational by 2015. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information). Medical data (for example, record of allergies) would be securely shared, for those patients who had consented, with other providers of health care to support delivery of emergency care. For example, when a patient attended a hospital A&E department.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

We spoke with health visitors and district nurses during the inspection. Both described good working relationships with the practice and we saw that a quarterly meeting between the GPs and health visitors took place to discuss and plan the care for children identified as at risk. Both groups of staff told us they were able to access the electronic records of patients they were delivering care and support to and were able to add entries to patient records to keep GPs up to date with their involvement.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the GPs we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We were told that one GP had a deeper knowledge of the Mental Capacity Act 2005 and colleagues could seek advice from this GP if needed. We saw that the practice had a checklist to use in supporting patients subject to end of life care. This included discussion with the patient or others acting in their best interest on whether to document do not attempt to resuscitate instructions.

Patients with learning disabilities and those with dementia were supported to make decisions. We saw evidence of the involvement of a family member in supporting a patient with learning disability make a decision about their future care. This showed GPs were aware of how to ensure a patient's best interests were taken into account if a patient did not have capacity to make decisions or consider the information provided to them. The GPs we spoke with demonstrated a clear understanding of Gillick competencies. (These help GPs and nurses to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). All GPs were aware that the competency principle would not be applied to a patient under the age of 13.

There was a practice policy for documenting consent for specific interventions. For example, written consent was obtained for all minor surgical procedures. We saw an audit that confirmed all patients who had a coil fitted gave written consent to the procedure.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all of these patients were offered, and encouraged to take up, an annual physical health check. However, only 60% of these patients had received their health check at the time of inspection. This was a low take up of health checks compared to other practices. The practice had also identified the smoking status of 82% of patients over the age of 16 and actively offered nurse led smoking cessation clinics to these patients. Over 98% of patients with either Asthma or COPD (lung disease) received smoking cessation advice. Similar mechanisms of identifying at risk groups were used for patients who were obese and those receiving end of life care. A visiting dietician was available to support patients identified as obese.

The practice's performance for cervical smear uptake was 80% which was similar to other practices in the CCG. There was a policy to send reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. A specialist women's health nurse undertook all cervical smears to ensure consistency and quality of results.

The practice took part in the national chlamydia, mammography and bowel cancer screening programmes. There was evidence that they were among the top performers within the CCG for take up of bowel screening. The practice had received an incentive award from the CCG for improving uptake by more than 3% in the year ending in December 2013. There was a system to follow up patients who did not attend these 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 childhood immunisations was just below the national target of 90%. Data showed us that 56% of carers had received a flu immunisation in 2013. This was better than most practices achieved for this group. There was a procedure for following up non-attenders.

A wide range of health promotion material was available in the practice waiting room and via the website. The website contained a page entitled 'Family Health'. This included sections specific to the needs of different patient populations registered. For example, there was a section dedicated to child health for six to fifteen year olds and another section on sexual health. GPs showed us evidence of using health promotion material from national websites to support the verbal advice they gave patients on improving their health and lifestyle.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent patient satisfaction data available for the practice. This included information from the national patient survey, to which 121 patients responded, and a survey of 411 patients undertaken by the practice's patient participation group (PPG). The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the national patient survey showed 99% of patients said they had confidence in their GP. Ninety per cent rated being treated with care and concern as good or very good.

We spoke with eight patients on the day of inspection. The feedback we received was generally favourable. Patients completed CQC comment cards to provide us with feedback on the practice. We received 42 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good care and treatment service and staff were helpful and caring. They said staff treated them with dignity and respect.

Staff and patients told us consultations and treatments were carried out in the privacy of either the GPs consulting room or treatment room. Curtains were provided in consulting rooms and treatment rooms to maintain privacy and dignity during examinations, investigations and treatments. We noted that both consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We observed staff treating patients with kindness and speaking quietly to individual patients to maintain confidentiality. When patients took the opportunity to comment on privacy and compassion on the CQC comment cards all responses were very favourable.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Calls from patients were taken in an office away from reception where conversations could not be overheard by patients booking in or waiting to be seen. A notice was prominent requesting only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations with the reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Reception staff we spoke with told us the system worked well. There was a room available near reception for patients who wished to speak in confidence with reception staff.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 83% of practice respondents said the GP involved them in care decisions and 78% felt the GP was good at explaining treatment and results. Both these results were above average compared to CCG and national results. The results from the practice's own satisfaction survey showed that 86% of patients said they were sufficiently involved in making decisions about their care. This was also above the average for the CCG.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. This was also reflected by patients who completed comment cards. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make decisions about the choice of treatment they wished to receive.

Data showed us that all patients with long term mental health conditions had a care plan that had been agreed with them. There were care plans in place for patients receiving end of life care. These contained the patient's preferred place of death and we saw that this had been respected in all cases in the past year. Patients with a learning disability also had an agreed care plan recorded.

Staff told us that translation services were available for patients who did not have English as a first language. The practice website carried a translation facility into 80 languages.

Patient/carer support to cope emotionally with care and treatment

The responses on comment cards we reviewed told us that staff offered compassionate support to patients when needed. We heard that patients could be accompanied by

Good

Are services caring?

a relative during a consultation if they wished and that chaperones were available to support patients during examinations and treatment. We saw parents accompanying children to their consultation. Translation services were available for patients whose first language was not English.

The practice held a register of patients who were also carers and we saw that information for carers was available in the waiting room. For example, information on local carer support groups. When carers could not attend the practice because they were supporting the person they cared for they were offered home visits. We heard how elderly patients finding it difficult to make appointments at hospital were given support to do so. Some of these patients had told staff how helpful they found this support.

We heard from patients how the GPs and nurses supported them in understanding a long term medical condition and to cope with the possible changes in their health. There was information available in both the waiting room and on the practice website on local and national voluntary groups that offered support for patients with long term conditions.

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 patient 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. A range of disease registers were in place that identified patients with long term conditions, those requiring end of life care and patients with learning disabilities. These enabled the practice to set up recall systems to ensure these patients received care and support at appropriate intervals. We saw that recall systems enabled the practice to meet the needs of patients with long term conditions. QOF data showed the practice to be performing well and meeting most targets set for the care of this group of patients.

All patients were allocated a named GP which supported continuity of care. The patients we spoke with and comment cards we reviewed showed that patients felt their GP understood their needs. Longer appointments were available for patients who needed them and those with long term conditions. Home visits were carried out when patients needed this service and patients in local care homes were visited by their named GP when their medical condition required. Health visitors we spoke with told us they were informed of housebound patients promptly and were able to offer services to these patients.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the patient participation group (PPG). For example, a new media screen offering a range of health information was installed as a consequence of the action plan from the last PPG patient survey.

The practice had achieved and implemented the gold standards framework for end of life care. They had an end of life care register and had regular multidisciplinary meetings to discuss patient and their families care and support needs. We saw the practice conducted an audit of end of life care that showed over 24% of these patients died at home (their preferred place of death) this was higher than the local and national results.

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) with the out of hours service to ensure, timely communication of changes in care and treatment. The notification level achieved by the practice was one of the highest in the CCG.

A range of services were available at the practice. These included physiotherapy, a visiting dietician, ultrasound and a dermatology clinic. These and other additional services provided convenient access for patients and reduced the need to travel to the hospital or other clinics. Physiotherapy services supported patients whose work commitments made attending hospital difficult and a podiatry service at the practice meant older patients did not have to travel to alternative clinics in the area.

QOF data showed the practice achieved all the targets for supporting patients with mental health problems. Referrals to specialist services for patients with mental health problems were made when the patient's condition required and a talking therapy service was available at the practice. We heard that GPs were concerned that the specialist service for supporting young patients with mental health problems was experiencing pressure and consequently patients could wait nine months before they were seen. The practice had expressed their concerns regarding access to this service. Information from the local clinical commissioning group showed that this service was being reviewed.

Tackling inequity and promoting equality

The practice recognised the needs of their patients. A translation service could be accessed from the local hospital. Patients whose first language was not English could bring a relative or friend with them to their appointment to translate for them if they preferred. An induction loop system was available to support patients with a hearing impairment (an induction loop amplifies voice to assist patients using a hearing aid). Written information could be made available in large print for patients with a visual impairment.

All patients with a learning disability and a long term mental health problem had a named GP to support their needs and develop care plans with them.

A carers' register was in place. Carers could request a home visit if they found it difficult to leave the person they cared for. Information on support services for carers was provided via leaflets in the waiting room or from the patients GP.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

All consulting and treatment rooms were located on the ground floor. The practice had wide corridors enabling access for wheelchairs and mobility scooters. This made movement around the practice easier and helped to maintain patients' independence. There were no steps to the practice entrance and automated doors enabled access for patients who were frail or had mobility problems.

The practice had an open registration policy enabling everyone who lived within the practice area to register as a patient. There was evidence that the practice population had increased during the last three years.

A small waiting area away from the main reception and waiting area was available for patients who needed to wait nearer the consulting rooms or those with a possible infectious disease. This was also available to parents with young children in prams or buggies.

Access to the service

Appointments were available from 8:30am to 5:30pm on weekdays and the practice was open until 6.30pm. There was a mix of appointments available including routine appointments bookable in advance, on the day urgent appointments and telephone consultations. A duty GP system was in operation to ensure that all patients who called requiring support from a GP were either seen, on the day they called, or received a phone call to assess their medical needs.

Later appointments were available from Monday to Thursday between 6:30pm and 7pm. At the time of inspection the practice was open every other Saturday between 8am and 12noon. This service was particularly useful for patients whose work commitments made it difficult to attend during the usual working day. From 8 November 2014 the practice was opening every Saturday morning offering appointments that could be booked on the day or in advance. Three GPs were going to be on duty every Saturday morning. This service was going to run through winter months. Additional book on the day surgeries were commencing on Friday 7 November to further increase the availability of appointments during the winter period when demand was higher. These clinics would be held in both the morning and afternoon.

Information on the range of appointments and how to book them was available on the practice website. Options were available for the booking of appointments. Patients could book an appointment by telephone, online or by visiting reception. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring. Information on the out-of-hours service was provided in the waiting room, on the practice website and in the patient information leaflet.

Patients were generally satisfied with the appointments system. The national patient survey data showed 84% of patients described their experience of making an appointment as good or very good. This was above the local average score. Eighty two per cent of responses to the national survey said they were satisfied with the practice opening hours. This was also better than the local average. We were told that GPs had, in the last two years, changed the days on which they worked to ensure more appointments were available on busy days.

We saw that the waiting room accommodated patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. However, some patients commented that the waiting room became crowded at peak times. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice manager and a lead GP were responsible for ensuring all complaints were dealt with in accordance with the practice policy.

Information was available to help patients understand the complaints system. A poster setting out how to make a complaint was displayed by the reception desk. Staff we spoke with were able to tell us how they would support a patient wishing to make a complaint. They told us that a complaints form was available at reception and this would be handed to patients upon request. The complaints procedure was also detailed on the practice website and in the patient information leaflet. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the complaints log for 2014. This contained 10 complaints received between January and October. All

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

complaints had been dealt with in accordance with the practice complaints procedure. The complaints had been acknowledged, investigated and responded to in a timely manner. We saw that when a complainant was unhappy with an initial response the matter was referred to the designated GP dealing with complaints who resolved the patient's concerns.

The practice reviewed complaints annually. Individual complaints received were discussed at practice meetings in the month they were received. We saw a summary of the complaints review carried out in 2013. This showed 11 complaints had been reviewed. Learning from individual complaints was disseminated to staff via their line managers.

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

There was a core ethos within the practice of delivering the best possible care and treatment in a timely manner for all patients. Discussions we held with GPs and staff showed us that this philosophy was topmost on everyone's agenda. Patients' views supported that the practice delivered patient focussed services because the national patient survey showed the practice as having the highest rating in the CCG area of 97% of patients who would recommend the practice to others. The practice charter setting out how the practice would deliver services was available on the patient website. The practice did not have a strategic business plan.

There was evidence to support the practice delivered wide ranging additional services to their patients. For example, there were clinics held at the practice by dieticians, podiatrists and physiotherapists. The practice had taken the opportunity to be involved in all enhanced services available. This included additional GP clinics to relieve the pressure on A&E departments during winter months.

Governance arrangements

The practice had a range of policies and procedures that supported the day to day operation of the service. These were held on the practice computer system in a file that was accessible to all staff. Staff we spoke with knew where the file was and how to access it. Policies and procedures files were also held by the practice manager who provided us with sight of these documents very promptly when requested. We looked at seven policies and found they had been reviewed within the last year and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. In many areas of QOF the practice performed better than the rest of the CCG. QOF data was regularly discussed at GP and nurse team meetings and reports at individual GP level were used to support improvement. Each GP received data that showed how many of their named patients with long term conditions required review and they were responsible for ensuring the care targets were achieved.

GPs took responsibility for different aspects of the clinical and day-to-day operation of the practice. For example, one GP led on QOF and another GP was the lead for safeguarding. The nurses and administration staff we spoke with were aware of the various GPs responsibilities. There were a range of staff meetings. Nursing staff met as a team as did the reception staff. Clinical meetings were held on a weekly basis and multidisciplinary team meetings took place once every six to eight weeks.

The practice had completed a number of clinical audits, for example an audit of end of life care and an audit of the smoking status of young patients diagnosed with asthma. We reviewed a total of 11 audits. One audit we reviewed showed the practice took action to ensure patients received a regular blood test when taking a particular medicine which required close monitoring.

The practice had arrangements for identifying, recording and managing risks. We saw policies accompanied by risk assessments. For example, fire risk assessments and manual handling risk assessments.

Leadership, openness and transparency

There were clear lines of management responsibility within the practice. Staff we spoke with told us they could raise issues with their line manager and were confident these would be passed on to senior managers or partners if their manager could not resolve the matter. There were notes of meetings showing team leaders took part in management meetings and that information was fed two ways via this group. Staff we spoke with also told us that GPs and the practice manager were approachable and responsive to both ideas for improvement and in solving matters of concern.

The practice manager was responsible for maintaining records relating to staff and to the day to day management of the service. We found these to be kept in good order and readily available. An electronic record of policies and procedures was maintained and staff we spoke with were aware of where this record was kept and how to access it for reference. The team leaders we met were knowledgeable and staff we spoke with told us their managers were supportive.

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

The practice worked with an active patient participation group (PPG). We met two members of the PPG who were enthusiastic about the input of the group in influencing the way the practice delivered services. They both told us how

Are services well-led?

Good

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

the group was involved in planning and supporting the annual patient satisfaction survey. We heard that the PPG reviewed the results of the survey and agreed an action plan with the practice. We saw that as a result of feedback via the PPG a new information screen had been installed in the waiting room. This provided a range of health promotion information, information about local services and advice on the services available at the practice.

The practice had gathered feedback from staff through both appraisals and day to day comments fed through line managers. Staff were also able to offer feedback through their team meetings. For example, the nursing team met every six to eight weeks. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with and management.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and on the shared information file on the practice computer system.

Management lead through learning and improvement

All staff had regular training and development opportunities. Staff received an appraisal each year to discuss their training and development needs for the year ahead. Some staff we spoke with gave us examples of how they had accessed additional training for example, training in the use of the computer system and customer services training. Staff we spoke with told they would feel able to request training that was relevant to their role and to support patient care. They felt confident that such requests would be considered and in most cases supported.

Practice staff took an active part in attending training provided by the CCG. Staff we spoke with told us they valued the opportunities this gave them to keep up to date. The practice was a GP training practice and had been subject to a training revalidation visit in 2013.