Nelson Medical Group

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

We carried out a comprehensive announced inspection at Nelson Medical Group on 12 March 2015. Overall, the practice is rated as good. Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led services. The practice was also good at providing services for the six key population groups we looked at during the inspection.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed. However, the actual recording of significant events could be improved;
- Risks to patients were assessed and well managed;
- The practice was clean and hygienic, and good infection control arrangements were in place;
- Patients' needs were assessed and care was planned and delivered following best practice guidance;
- Most patients told us they were treated well and received a good service. Findings from the most recent National GP Patient Survey showed patient satisfaction levels were varied, but most were broadly in line with the local Clinical Commissioning Group (CCG) and national averages. Good feedback was received about the care and treatment provided by the practice nurses. However, not all patients were satisfied with access to appointments or appointment waiting times. This had been acknowledged by the practice and staff were taking action to address these concerns in collaboration with their patient participation group;
- Information about the services provided by the practice was readily available and easy to understand, as was information about how to raise a complaint;
- The practice had satisfactory facilities and was suitably equipped to treat patients and meet their needs;
- There was a clear leadership structure and good governance arrangements. The practice actively sought feedback from patients.

However, there was an area of practice where the provider needs to make improvements. Importantly the provider should:

- Ensure that significant events are recorded fully and include any action taken and lessons learnt.

Summary of findings

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.

The nationally reported data we looked at as part of our preparation for this inspection did not identify any concerns relating to safety. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The GP partners and practice management team took action to ensure lessons were learned from any incidents or concerns, and shared these with other staff to support improvement. However, the recording of significant event reporting could be strengthened by including more information about lessons learnt and how the impact of any changes introduced would be monitored. There was evidence of good medicines management. Good infection control arrangements were in place and the practice was clean and hygienic. Safe staff recruitment practices were followed and there were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

The nationally reported data we looked at as part of our preparation for this inspection did not identify any concerns relating to the provision of effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE), and the local Clinical Commissioning Group (CCG). Staff had received training appropriate to their roles and responsibilities. The practice had made suitable arrangements to support clinical staff with their continuing professional development. There were systems in place to support effective multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services.

Most patients told us they were treated well and received a good service. Findings from the most recent National GP Patient Survey showed patient satisfaction levels were varied, but most were broadly in line with the local Clinical Commissioning Group (CCG) and national averages. Good feedback was received about the care and treatment provided by the practice nurses. The practice had acknowledged that they had lower patient satisfaction levels in

Summary of findings

some areas and were taking action to address these concerns in collaboration with their patient participation group. Arrangements had been made to ensure patients' privacy and dignity was respected. Patients had access to information and advice on health promotion, and they received support to manage their own health and wellbeing. Staff demonstrated they understood the support patients needed to cope with their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Services had been planned to meet the needs of the key population groups such as older patients. The practice had satisfactory facilities and was appropriately equipped to treat patients and meet their needs. There was an accessible complaints procedure, with evidence demonstrating staff made every effort to address any concerns raised with them.

The majority of patients who spoke to us, or who completed CQC comment cards, raised no concerns about access to appointments. However, some of the patients we spoke to on the day of the inspection told us they had experienced difficulties obtaining an appointment. The practice had also received similar feedback from some patients who had completed the National GP Patient Survey published in January 2015. The practice had acknowledged these concerns and was taking action to address them in collaboration with their patient participation group, and through their participation in a local extended hours project to improve patient access. Action was also being taken to address the high rates of patients failing to attend for their appointments which they hoped would lead to the availability of more appointments.

Are services well-led?

Good

The practice is rated as good for providing well led services.

The practice was well managed, and good governance arrangements were in place. The clinical team demonstrated good professional values and had a clear ethos which underpinned their work. They were working hard to improve the services they provided to patients by, for example, participating in a local scheme to improve patient access to appointments over key times of the year. An effective governance framework was in place. Staff were clear about their roles and understood what they were accountable for. There were a range of policies and procedures covering the activities of the practice. Systems were in place to monitor and, where relevant, improve the quality of the services provided to patients. The practice actively sought feedback from patients and used this to improve the services they provided.

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 Quality and Outcome Framework (QOF) data for 2013/14 showed the practice had achieved good outcomes in relation to majority of the conditions commonly associated with older people. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with heart failure. This was 0.7 percentage points above the local Clinical Commissioning Group (CCG) average and 2.9 points above the England average.

Staff provided proactive, personalised care to meet the needs of older people. The practice provided a range of enhanced services including, for example, a named GP who was responsible for overseeing the care and treatment received by older patients. Clinical staff had received the training they needed to provide good outcomes for older patients. Staff were responsive to the needs of older patients and offered home visits and access to same-day appointments for those with urgent needs.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions.

Nationally reported QOF data for 2013/14 showed the practice had achieved good outcomes in relation to the majority of conditions commonly associated with this population group. For example, they had obtained 100% of the points available to them for providing recommended care and treatment to patients with chronic obstructive pulmonary disease (COPD). This was 0.7 percentage points above the local CCG average and 2.9 points above the England average.

Staff had taken steps to reduce unplanned hospital admissions by improving services for patients with complex healthcare conditions. All the patients on the practice's long-term conditions registers received healthcare reviews that reflected the severity and complexity of their needs. Clinical staff had the training they needed to provide good outcomes for patients with long-term conditions.

Families, children and young people

Good

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

Summary of findings

Staff had identified the needs of families, children and young people and put plans in place to meet them. Nationally reported QOF data, for 2013/14 showed the practice had achieved 100% of the total points available to them for providing maternity services and child health surveillance. These achievements were above the England averages (i.e. 0.9 and 1.2 percentage points above respectively) and in line with the local CCG averages.

Systems were in place for identifying and following-up children who were considered to be at risk of harm or neglect. Where comparisons could be made, we found the average percentages for the delivery of childhood immunisations were just below the overall averages for the local CCG. Ante-natal appointments were offered by healthcare professionals attached to the practice and new mothers had access to a baby clinic service. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age patients (including those recently retired and students.)

Staff had identified the needs of the working age and recently retired population and had developed services which met their needs. Nationally reported QOF data for 2013/14 showed patient outcomes relating to the conditions commonly associated with this population group were above the local CCG and England averages. For example, the practice had achieved 100% of the total points available to them for providing care and treatment to patients with cardiovascular disease. This was 4.6 percentage points above the local CCG average and 12 points above the England average.

The practice was proactive in offering on-line services to patients. For example, patients could order repeat prescriptions and book appointments on-line. Health promotion information was available in the waiting area and there were links to self-help information on the practice website. The practice provided additional services such as travel vaccinations and a smoking cessation service. The practice was part of a group of local GP practices that were working in partnership to provide extended hours appointments.

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.

Systems were in place in place to identify patients, families and children who were at risk or vulnerable. Nationally reported QOF data, for 2013/14, showed the practice had achieved good outcomes

Summary of findings

for patients with learning disabilities. For example, the practice had obtained 100% of the points available to them for providing recommended care and treatment for patients with learning disabilities. This was 10.3 percentage points above the local CCG average and 15.9 points above the England average.

Staff worked with relevant community healthcare professionals to help meet the needs of vulnerable patients. They sign-posted vulnerable patients to various support groups and other relevant organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children and took action to protect vulnerable patients. Staff understood their responsibilities regarding the sharing of information, the recording safeguarding concerns and contacting relevant agencies.

People experiencing poor mental health (including people with dementia)

Good

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

Nationally reported QOF data for 2013/14 showed the practice had achieved good outcomes in relation to patients experiencing poor mental health. For example, the practice had obtained 98.5% of the points available to them for providing recommended care and treatment for patients with mental health needs. This was 2.6 percentage points above the local CCG average and 8.1 points above the England average. They had also received 100% of the points available to them for treating patients with dementia. Again, this was above the local CCG and England averages.

The practice kept a register of patients with mental health needs which was used to ensure they received relevant checks and tests. Where appropriate, care plans had been completed for patients who were on the register. The practice regularly worked with other community healthcare professionals to help ensure patients' needs were identified, assessed and monitored.

Summary of findings

What people who use the service say

During the inspection we spoke with two patients from the patient participation group (PPG), and five other patients who visited the practice on the day of our inspection. We also reviewed 41 Care Quality Commission (CQC) comment cards completed by patients. The feedback we received indicated the majority of patients were satisfied with the care and treatment they received. Most patients told us they were treated well and received a good service. Findings from the most recent National GP Patient Survey showed patient satisfaction levels were varied, but most were broadly in line with the local Clinical Commissioning Group (CCG) and national averages. For example, of the patients who responded to the survey:

- 87% said the last GP they saw, or spoke to, was good at listening to them, (this was below the local clinical commissioning group (CCG) average of 92% and the national average of 88%);
- 84% said the last GP they saw or spoke to was good at giving them enough time, (this was below the local CCG average of 90% and the national average of 86%);
- 73% said the last GP they saw or spoke to was good at treating them with care and concern, (this was below the local CCG average of 86% and the national average of 82%);
- 73% said the last GP they saw or spoke to was good at explaining tests and treatments, (this was below the local CCG average of 87% and the national average of 82%);
- 91% said they had confidence and trust in the last GP they saw or spoke to, (this was below the local CCG average of 95% and the national average of 93%).

Good feedback was received about the care and treatment provided by the practice nurses. However, not all patients were satisfied with access to appointments or appointment waiting times. This had been acknowledged by the practice and staff were taking action to address these concerns in collaboration with their patient participation group.

These results were based on 101 surveys that were returned out of a total of 264 sent out. The response rate was 38%.

Areas for improvement

Action the service SHOULD take to improve

The practice should:

- Ensure that significant events are recorded fully and include any action taken and lessons learnt.

Nelson Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team also included a practice nurse and a GP.

Background to Nelson Medical Group

Nelson Medical Group provided care and treatment to 5862 patients of all ages, based on a General Medical Services (GMS) contract agreement for general practice. They are part of NHS North Tyneside Clinical Commissioning Group (CCG) and provide care and treatment to patients living in Whitley Bay. The practice serves an area that has lower levels of deprivation for children and people in the over 65 age group, than the local CCG average. The practice's population has fewer patients aged under 18 years, and more patients aged over 65, than other practices in the CCG area.

The practice provides services from the following address: Nelson Medical Group, Cecil Street, North Shields, Tyne and Wear, NE290DZ. We visited this site during our inspection.

The practice occupies purpose built premises which are fully accessible to patients with mobility needs. Nelson Medical Group provides a range of services and clinic appointments including, for example, services and clinics for patients with asthma, diabetes and hypertension. The practice consists of three GP partners (one female and two males), a practice manager, a nurse practitioner, three nurses, a healthcare assistant, and seven administrative and reception staff.

When the practice is closed patients can access out-of-hours care via Northern Doctors Urgent Care and the NHS 111 service.

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.

How we carried out this inspection

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

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

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

Detailed findings

- 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)

Before visiting we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the services it provided. We carried out an announced inspection on 12 March 2015. During this we spoke with a range of staff including: one of the GP partners; the practice manager; a practice nurse and members of the reception and administrative team. We spoke with two patients from the Patient Participation Group (PPG) and five other patients who visited the practice on the day of our inspection. We observed how staff communicated with patients who visited, or telephoned the practice on the day of our inspection. We looked at records the practice maintained in relation to the provision of services. We also reviewed 41 Care Quality Commission (CQC) comment cards that had been completed by patients who use the practice.

Good

Are services safe?

Our findings

Safe Track Record

When we first registered this practice, in April 2013, we did not identify any safety concerns that related to how it operated. Also, the information we reviewed as part of our preparation for this inspection did not identify any concerning indicators relating to safety. The Care Quality Commission (CQC) had not received any safeguarding or whistle-blowing concerns regarding patients who used the practice.

The practice used a range of information to identify potential risks and to improve patient safety. This information included significant event reports, national patient safety alerts, and comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. The patients we spoke with, or who had completed comment cards, raised no concerns about safety at the practice.

Staff kept records of significant events and incidents. We reviewed a sample of the records completed during the previous 12 months, as well as the minutes of meetings where these were discussed. The records showed the practice had managed such events consistently and appropriately during the period concerned. This provided evidence of a safe track record for the practice.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and learning from significant events and complaints. The practice manager told us significant events were discussed, where appropriate, at the monthly practice meetings and any necessary actions were agreed by those present. The staff we spoke with were aware of the system in place for raising issues and concerns. Staff reported relevant incidents to the local CCG, using the local safeguarding incident reporting system.

Staff had identified and reported on five significant events during the previous 12 months. The records of significant events we looked at demonstrated staff took appropriate action in relation to any concern they identified about the safety of their patients, and informed the relevant agencies. For example, one of the events concerned a patient who had had their medication changed when they were discharged from hospital. When the nurse practitioner saw the patient at the practice they realised there had been a prescribing error. They told the practice manager who then informed the local hospital to make them aware of this concern. However, the recording of significant events lacked sufficient detail to provide a clear view of the lessons learned and how any changes would be monitored.

Arrangements had been made which ensured national patient safety alerts were disseminated by the practice manager to the relevant team members. The nurse practitioner we spoke with told us any safety alerts that were relevant to the nursing team were always forwarded via email. They said all alerts were saved in a specific place on the practice's computer intranet system. The practice's approach to managing safety alerts enabled the relevant staff to take appropriate action to promote patient safety, and to mitigate any risks. (Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice.)

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to children, young people and vulnerable adults. Safeguarding policies and procedures were in place. Information about how to report safeguarding concerns and contact the relevant agencies was easily accessible. One of the GP partners acted as the designated lead role for safeguarding children and vulnerable adults. Staff we spoke with said they knew which GP acted as the safeguarding lead.

All of the GPs had completed child protection training to Level 3. This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns. Nursing staff had completed Level 2 training which is more relevant to the work they carried out. The practice manager told us administrative staff had also completed safeguarding training. This was confirmed by a member of the reception team we spoke with. Staff demonstrated a good understanding of how to protect and safeguard patients. They were clear about what they would look for, and what they would do if they had any concerns about a patient's wellbeing.

A chaperone policy was in place and information about this had been displayed throughout the practice. The patients

we spoke with said they knew they could access a chaperone if they needed one. All the clinical and non-clinical staff who carried out chaperone duties had undertaken chaperone training and undergone a Disclosure and Barring Service (DBS) check.

Regular multi-disciplinary team meetings took place. The GPs met with health visitors and other healthcare professionals to review patients considered to be at risk and, where appropriate, to share any relevant information. A process was in place which helped to ensure that any at risk children who missed important appointments were followed up by the practice team. For those children who had been identified as being at risk of harm staff had coded their patient records to alert clinicians of their circumstances.

Medicines Management

Medicines were stored safely and suitable arrangements had been made to assure the security of prescription pads. We confirmed the practice did not hold any controlled drugs. (Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation, and stricter legal controls are applied to prevent them from being misused, obtained illegally or causing harm.)

An up-to-date cold-chain policy was in place which provided staff with guidance regarding how medicines requiring cold storage should be stored. Refrigerator temperatures were checked daily to help ensure medicines requiring cold storage, such as vaccines, were stored within the right temperature range. A log had been kept by the practice to confirm this. Vaccine stocks were rotated to ensure they were used before their expiry dates.

There were effective arrangements for monitoring the expiry dates of emergency medicines and for ordering new supplies. The GPs monitored the expiry dates of the medicines they kept in in their own doctor's bag. We found all emergency medicines were in date, as were the sample of medicines we checked in the doctor's bag we looked at.

Patients were able to order repeat prescriptions in a variety of ways, including using a dedicated telephone line and on-line. The practice website provided patients with helpful advice about ordering repeat prescriptions. Reception staff handled telephone requests for these competently and safely. They were clear about the processes they should follow, including checking that the number of authorised repeat prescriptions had not been exceeded. The nurse practitioner told us medicine reviews usually took place every six or 12 months, depending on the type of medicines prescribed. Repeat prescription requests were signed by GPs after each surgery session. The receptionist we spoke with said the repeat prescription processes worked well.

The practice had implemented the Electronic Prescription System (EPS) to help reduce errors in clinical prescribing. The practice manager told us the system provided clinicians with alerts about potential prescribing errors. The EPS also enables prescribers, such as GPs and nurses, to send prescriptions electronically to a pharmacy, where this is the patient's preferred choice.

Vaccines were administered by the practice nurses in line with patient group directions (PGDs). (PGDs are specific guidance on the administration of particular medicines and provide authorisation for nurses to administer them.) We saw up-to-date copies of the PGDs were held by each of the nurses. However, some of the PGDs we looked at did not contain a signature from an appropriate clinician.

A system was in place for responding to any medicine related safety alerts received by the practice. The practice manager told us they ensured that alerts were forwarded to the relevant members of staff.

Cleanliness & Infection Control

The premises were clean and hygienic throughout. The patients we spoke with, and those who commented on this in the CQC comment cards, told us the premises were always clean. Cleaning services were provided by an external contractor who worked to a cleaning schedule. The practice manager had access to the cleaning schedule and confirmed it was up-to-date.

The clinical rooms we visited contained personal protective equipment such as latex gloves and paper covers for the consultation couches. Arrangements had been made for the privacy screens to be laundered on a regular basis. Spillage kits were available to enable staff to deal safely with spills of bodily fluids. A member of the reception team we spoke with was clear about how bodily spills should be handled. Sharps bins were available in each treatment room to enable clinicians to safely dispose of needles. These had been appropriately signed and dated. Clinical rooms contained hand washing sinks, antiseptic gel and hand towel dispensers to enable clinicians to follow good hand hygiene practice.

Good

Are services safe?

Arrangements had been made for the safe handling of specimens and clinical waste. For example, reception staff were clear about how to handle specimens safely to minimise the risk of the spread of infection. All of the waste bins we saw were visibly clean and in good working order. However, there was no bin in one of the rooms we visited which meant there was no appropriate receptacle to safely dispose of any waste. Appropriate arrangements were in place to ensure that the practice's water systems were kept free of the presence of Legionella. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.)

Infection control procedures were in place. These provided staff with guidance about the standards of hygiene they were expected to follow. The practice had an infection control lead who also provided guidance and advice to staff when needed. The infection control lead told us an infection control risk audit had been completed within the previous 12 months, to help identify any shortfalls or areas of poor practice. Appropriate arrangements had been put in place to ensure that the concerns identified were addressed.

Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. The equipment was regularly inspected and serviced. For example, equipment contained in the emergency medicines kit had been checked during the previous 12 months. Other medical equipment had been calibrated to make sure they were operating effectively. Arrangements had been made to ensure fire safety equipment was appropriately maintained.

Staffing & Recruitment

The practice had a recruitment policy which provided guidance about the processes that should be carried out when appointing new staff. However, although the policy had been reviewed in January 2015, the guidance provided did not comply fully with the relevant regulation.

A range of pre-employment checks had been undertaken to help make sure only suitable staff were employed. Where relevant, staff had undergone a Disclosure and Barring Service (DBS) check. References and applicants' employment histories had been obtained. All GPs, nurses and non-clinical staff had a NHS Smart card (containing an identity photograph). This meant their identity had been verified under the NHS Employment Check Standards process.

The GP partners had each undergone a DBS check as part of their application to be included on the National Medical Performers' List. (All performers are required to register for the online DBS update service which enables NHS England to carry out regular status checks on their DBS certificate.) We checked the General Medical and Nursing and Midwifery Councils registers and confirmed all of the clinical staff working at the practice were appropriately registered. (It is a requirement that all clinical staff are registered with the relevant regulatory body before they can practice.)

Monitoring Safety & Responding to Risk

The practice had systems in place to manage and monitor risks to patients and staff. For example, an up-to-date fire risk assessment was in place demonstrating the practice had assessed the potential risks to staff and patients. The building was safe and hazard free. None of the patients we spoke to raised any concerns about health and safety. The practice completed significant event reports where concerns about patients' safety and well-being had been identified. Arrangements were in place to learn from patient safety incidents and to cascade this learning within the team.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. For example, there was an up-to-date business continuity plan for dealing with a range of potential emergencies that could impact on the daily operation of the practice. The plan covered the actions to be taken to reduce and manage a range of potential risks. The practice manager told us staff had received training in cardio-pulmonary resuscitation (CPR). There was equipment available for use in emergencies including oxygen, adrenaline and a defibrillator. (Adrenaline is used to treat life-threatening allergies).

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. All clinical staff had access to local guidelines, as well as guidelines from the National Institute for Health and Care Excellence (NICE). The clinicians we spoke with confirmed there was a system in place for updating practice guidelines to ensure they reflected any changes to national and local clinical guidelines. From our discussions with clinical staff we were able to confirm they completed thorough assessments of patients' needs which were in line with NICE guidelines and local protocols. Patients' needs were reviewed as and when appropriate. Nursing staff had access to a range of chronic disease management care plan templates. They used these to record details of the assessments they carried out and any agreements reached with patients about how they should manage their condition. There were leaflets with information about commonly found long-term conditions was available at the practice. The GPs and nurses used these to provide patients with the guidance they needed to manage their health.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in managing, monitoring and improving outcomes for patients. For example, GPs held clinical lead roles in a range of areas including for the most common long-term conditions, safeguarding and clinical governance. Staff had responsibilities for carrying out a range of designated roles. These included, for example, making sure emergency drugs were in date and fit for use, and monitoring performance in achieving the recommended levels of care and treatment set out in the Quality and Outcomes Framework (QOF).

Nationally reported QOF data for 2013/14 showed the practice had achieved 97.7% of the total overall points available to them for providing recommended treatments to patients with common health conditions. This was 0.9 percentage points above the local Clinical Commissioning Group (CCG) average and 4.2 points above the England average. The practice had achieved the maximum points available to them for all but seven of the QOF clinical indicators including, for example, those covering asthma, chronic obstructive pulmonary disease and epilepsy. The practice had just missed achieving full points for the clinical indicators relating to diabetes mellitus (92.3%) and mental health (98.5%) and for the public health indicators relating to blood pressure (95.9%) and smoking (97.8%). However, the practice had only obtained 76.4% of the points available to them for providing care and treatment for patients with peripheral arterial disease. This was 17.7 percentage points below the local CCG average and 14.8 points below the England average. With regard to the stroke and transient ischaemic attack clinical indicator, the practice's achievement of 83.1% was also below the local CCG and England averages. The team having considered these judged that there were justifiable reasons underpinning the practice's performance in relation to these areas. The information we looked at before the inspection did not identify the practice as an outlier for any QOF (or other national) clinical targets.

Staff had carried out clinical audits to help improve patient outcomes. This included a two-cycle audit by one of the GP partners. The audit checked whether the prescribing of medicines for patients with erectile dysfunction met with NHS prescribing restrictions. We saw the audit had been written up and the findings shared with the rest of the team at a practice meeting. Initial findings indicated that only 59% of eligible patients had been prescribed the most cost effective medicine as required by NHS prescribing restrictions. A follow up audit carried out a year later showed this had risen to 97% of eligible patients. Another two-cycle clinical audit had been carried out with regards to the prescribing of controlled drugs (CDs). The overall aim of the audit was to see whether GPs were prescribing CDs in line with the practice's 'Controlled Drugs Action Plan (CDAP). This had been developed to ensure patients were only prescribed CDs in line with best prescribing practice. The follow up audit found there had been an improvement in the prescribing of recommended CDs in line with the practice's CDAP. However, the audit also identified that action was needed to ensure that any locum GP working at the practice also followed the practice's CDAP. Staff acknowledged that they could be better at carrying out non-clinical audits which they hoped to address over the next 12 months.

Effective systems were in place which helped to ensure patients received prompt safe care and treatment. For example, all electronic and paper information, such as discharge and other advisory letters, were scanned onto

Good

Are services effective?

(for example, treatment is effective)

patients' medical records and given an appropriate READ code. The practice manager told us clinicians were notified of any incoming information so they could take appropriate action where this was needed.

Effective staffing

At the time of the inspection the practice had sufficient numbers of skilled, competent and experienced GP staff to meet their surgery commitments. The long-term absence of one of the GP partners had led to the increased use of locums. Steps were being taken to recruit an additional GP partner to help improve continuity of care for patients and minimise the need to access locum cover. The practice manager told us one of the practice nurses would soon be leaving their post. They told us they intended to use this as an opportunity to review how the hours attached to the post could be used in more effective ways.

The continuing development of staffs' skills and competence was recognised as integral to ensuring high quality care. For example, all three GP partners had completed the Royal College of Obstetricians and Gynaecologists qualification for non-specialists who work in women's health. Role specific training was also provided. One of the GPs had completed a recognised qualification in family planning. All of the GP partners had completed Level 3 training in child protection. Clinical staff attended local CCG training events and undertook other self-directed learning. Two members of the nursing team had completed training which enabled them to act as independent nurse prescribers. The nurse practitioner told us they had completed training in a range of areas relevant to their role and responsibilities including, for example, a Diploma in Asthma Care and training in diabetes management. They said they had also completed regular updates in other areas such as cervical screening and immunisations.

All the GP partners were up-to-date with their annual continuing professional development requirements and had either had been revalidated or had a date for their revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England.) Appropriate indemnity arrangements were in place for the GPs.

There were effective arrangements for the appraisal of staff. The staff we spoke with confirmed they had received an appraisal within the previous 12 months which set objectives for the forthcoming year and reviewed their training needs. The nurse practitioner we spoke with told us they had received an induction which had covered a range of areas, including use of the practice's IT system and fire prevention.

Working with colleagues and other services

The practice had developed positive working relationships, and forged close links with other health and social care providers, to help them co-ordinate care and meet patients' needs. The practice held monthly multi-disciplinary meetings to discuss patients with complex needs, for example, those with end-of-life care needs. These meetings were attended by the GPs, practice nursing staff as well as local healthcare professionals, such as health visitors, school nurses and medicine management staff. Staff were engaged in partnership working with other local GP practices to improve accessibility to appointments outside of surgery working hours.

Practice staff also worked with other service providers to meet patients' needs and manage complex cases. The practice received communications from a variety of sources, such as the local hospital, electronically and by post. Staff we spoke to were clear about their responsibilities for reading and actioning any issues arising from communications with other care providers. They understood their roles and how the practice's systems worked. A member of the reception team told us these systems usually worked well and everybody knew their part in making systems work.

Information Sharing

The practice had systems in place to provide staff with the information they needed to carry out their roles and responsibilities. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This enabled scanned paper communications, such as those from hospital, to be saved for future reference. The practice actively used an IT system to request and obtain pathology results electronically. They also used an electronic system to transfer patient electronic records to other practices using the same system.

Good

Are services effective?

(for example, treatment is effective)

The practice used several systems to communicate with other providers. For example, there was an agreed process for accessing information from the local out-of-hours provider. This ensured the practice received written information about any contact it had had with their patients. The practice shared information about patients with complex care and treatment needs with the out-of-hours and urgent care providers to help ensure they received appropriate care and treatment. The practice's clinical IT system enabled sharing of information with other healthcare professionals such as health visitors and the district nursing team. These arrangements helped ensure important information about patients' needs was shared in a secure and timely manner. Electronic systems were also in place for making referrals using 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).

Consent to care and treatment

The practice had a consent protocol which provided clinical staff with guidance about how to obtain patients' consent to care and treatment, and what to do if a patient lacked the capacity to make an informed decision. The practice's clinical staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in complying with it. All clinical staff had completed MCA training.

The GP partners we spoke with demonstrated a good understanding of consent and capacity issues. They were able to clearly explain when consent was necessary, and knew what to do if a patient lacked capacity to consent to their care and treatment. They were also clear about how to obtain consent from children and young people, and the use of the Gillick competence test. A policy was in place to support clinical staff when making such decisions about children and young people.

Health Promotion & Prevention

The practice supported patients to live healthier lives by providing routine checks. This included offering all new patients a health check with a member of the nursing team. This was used to obtain important information, such as details of alcohol consumption and whether the patient smoked, to help them provide appropriate health advice.

The practice also offered NHS Health Checks to all patients aged between 40 and 75 years of age, and offered patients opportunistic health screening, particularly in relation to smoking, obesity and exercise. The practice manager told us that, over the past five years, 821 patients had been invited to attend a NHS health check, and 266 had attended. This check helped to ensure patients were able to benefit from lifestyle advice and the early identification of potential health problems.

The QOF data for 2013/14 confirmed the practice supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy. The data also showed the practice had obtained 100% of the total points available to them for providing recommended care and treatment for patients diagnosed with obesity. This was in line with the local CCG and England averages. The practice manager told us that, during the previous three months, 24 patients who received smoking cessation advice had given up smoking. The practice had also obtained 100% of the points available to them for providing cervical screening to women. This was 0.5 percentage points above the local CCG average and 2.5 points above the England average. The practice told us that, during the previous five years, 82% of eligible women had taken up the offer of cervical screening.

Staff were good at identifying patients who needed additional support and they were proactive in offering this. For example, there was a register of all patients with dementia. Nationally reported QOF data for 2013/14 showed the practice had obtained 100% of the points available to them for providing recommended clinical care and treatment to dementia patients. The data indicated, for example, that 81.8% of patients with dementia had received a range of specified tests six months before, or after being placed on the practice's register. This was 0.5% percentage points below the local CCG average but 1.6 points above the England average.

The practice offered a full vaccination programme. Data reviewed by the CQC identified no concerns in relation to the percentage of patients aged 65 and over who had received a seasonal flu vaccination. Similarly, there were no concerns identified in relation to the percentage of patients aged over 6 months to under 65 years that received the seasonal influenza vaccination.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice regarding levels of patient satisfaction. This included information from the National GP Patient Survey of the practice, published in 2015.

Most of the 41 patients who completed Care Quality Commission (CQC) comment cards told us they were treated well and received a good service. This was confirmed by the patients we spoke with. Patients confirmed staff treated them with dignity, respect and compassion. Findings from the most recent National GP Patient Survey showed patient satisfaction levels were varied, but most were broadly in line with the local Clinical Commissioning Group (CCG) and national averages. For example, of the patients who responded to the survey:

- 87% said the last GP they saw, or spoke to, was good at listening to them, (this was below the local clinical commissioning group (CCG) average of 92% and the national average of 88%);
- 84% said the last GP they saw or spoke to was good at giving them enough time, (this was below the local CCG average of 90% and the national average of 86%).

Good feedback was received about the care and treatment provided by the practice nurses. The practice had acknowledged that they had lower patient satisfaction levels in some areas and were taking action to address these concerns in collaboration with their patient participation group.

During the inspection we observed that all consultations and treatments were carried out in the privacy of a consulting or treatment room. There were screens in these rooms to enable patients' privacy and dignity to be maintained during examinations and treatments. Consultation and treatment room doors were kept closed when the rooms were in use, so conversations could not be overheard. Patients were able to access a private room if they wished to talk confidentially to reception staff.

Care planning and involvement in decisions about care and treatment

Where patients had made comments on the CQC comment cards they completed, they all confirmed they were involved in decisions about their care and treatment. This was echoed in the comments made by the PPG members we spoke with. Data from the National GP Patient Survey of the practice, published in January 2015, showed patient satisfaction levels regarding their involvement in planning and making decisions about their care and treatment were broadly in line with the local CCG and national averages but there was room for improvement. The practice manager and the clinical team were aware of the survey's findings and there was an objective in the practice's business plan to consider how to improve patient satisfaction.

Staff told us translation and interpreter services were available for patients who did not have English as a first language. Providing these services helps to promote patients' involvement in decisions about their care and treatment. The practice website also contained a facility which enabled patients with limited language skills to translate all information into a language of their choice.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by practice staff. Staff had prepared an information pack which they sent to relatives of deceased patients to help them cope with their loss. Where patients had made comments on the CQC comment cards they completed, they all reported they were supported to cope with the emotional impact of their illness. This was also confirmed by the PPG members we spoke with. We observed staff in the reception area treating patients with kindness and compassion. Notices and leaflets in the waiting room sign-posted patients to organisations offering support with coping with loss. Clinical staff also referred patients struggling with loss and bereavement to these services. Carers looking after family members were identified at the new patient health check, or during a consultation. The practice manager told us a specific code was then added to their clinical record to alert clinicians to their particular needs.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of older patients. They kept a register of patients aged over 75 so they could plan their care effectively. The practice had written to each patient aged 75 years and over explaining which GP would act as their named doctor to help promote continuity of care. The practice provided extra services to a local care home through the Care Home Enhanced Service. In particular, clinical staff carried out routine visits to this home with a focus on assessment and care planning. Where appropriate, staff had also completed Do Not Attempt Resuscitation (DNAR) Orders. (This is a legal order which tells a medical team not to perform CPR on a patient.)

Staff had used a standardised risk assessment tool to profile patients according to the risks associated with their conditions. Staff maintained registers identifying the most vulnerable patients. The practice manager told us the needs of these patients were reviewed monthly to help ensure they were receiving appropriate support. For example, the practice had an at risk register of adults who had the most complex needs and 2.09% of these patients had an emergency care plan in place. The practice manager told us these were reviewed every three months.

The nursing team was responsible for delivering most of the care and treatment needed by patients with chronic diseases. The practice offered patients with long-term conditions, such as diabetes, an annual check of their health and wellbeing, or more often where this was judged necessary by the nursing team. Steps had recently been taken to introduce a better service for patients with long-term conditions, by assessing all of their health needs in a single visit. This was due to commence in April 2015. The Quality and Outcomes Framework (QOF) data for 2013/14 showed the practice had obtained 97.7% of the points available to them for providing recommended care and treatment for patients with long-term conditions. For example, the data showed 96.9% of patients diagnosed with Chronic Obstructive Pulmonary Disease (COPD) had received an influenza immunisation. (This was 0.5 percentage points above the local CCG average and 0.7 points above the England average.)

The QOF data for 2013/14 showed the practice had obtained 100% of the points available to them for providing recommended care and treatment to patients needing palliative care. (This was in line with the local CCG average and 3.3 percentage points above the England average.) The practice kept a register of patients who were in need of palliative care and their IT system alerted clinical staff about those who were receiving this care. QOF data showed that multi-disciplinary team (MDT) meetings took place at least every three months, to discuss and review the needs of each patient on this register. Staff told us these meetings included relevant healthcare professionals involved in supporting patients with palliative care needs, such as health visitors and palliative nurses.

The practice had identified the needs of families, children and young people, and put plans in place to meet them. Practice meetings involved health visitors and school nurses. This made it easier to carry out dedicated reviews of children identified as being at risk of harm and ensure, where appropriate, that referrals were made to relevant safeguarding professionals. Pregnant women were able to access antenatal clinic appointments provided by healthcare staff attached to the practice. The practice website included a link to a pregnancy care planner and information about general pregnancy topics, such as what to expect during the first weeks of being a new parent. The practice had obtained 100% of the QOF points available to them for providing recommended maternity services and carrying out specified child health surveillance interventions. These achievements were above the England averages (i.e. 0.9 and 1.2 percentage points above respectively) and in line with the local CCG averages. QOF data for 2013/14 showed antenatal care and screening were offered in line with current local guidelines. The data also showed that child development checks were offered at intervals consistent with national guidelines.

The practice offered a full range of immunisations for children. The health visitor attached to the practice provided a drop-in clinic for parents with children under five years. Where comparisons allowed, we found the delivery of childhood immunisations was mostly lower when compared with the overall percentages of children

Are services responsive to people's needs?

(for example, to feedback?)

receiving the same immunisations within the local CCG area. For example, with regard to seven of the eight childhood immunisations for children aged five years, the numbers who received these were below the local CCG averages. However, in most cases the practice had just fallen short of the local CCG averages.

The practice had planned its services to meet the needs of the working age population, including those patients who had recently retired. They provided access to appointments between 08:30am and 6:00pm each day, including over the lunch time period. Staff were actively working with other local practices to provide patients with access to extended hours appointments. We were told that, over the last Christmas period, clinicians from the group of practices involved in this initiative had provided patients with access to appointments outside of normal surgery hours. Plans had also been put in place to provide the same service over the forthcoming Easter holiday. The practice website provided patients with information about how to book appointments and order repeat prescriptions, and patients had access to a dedicated repeat prescription telephone line.

QOF data for 2013/14 showed the practice had obtained 100% of the points available to them, for providing recommended care and treatment to patients who had been diagnosed with the conditions most commonly affecting this population group. For example, the data showed that 98.4% of patients with hypertension (high blood pressure) aged over 16, had a record of intervention recorded in their medical records during the previous 12 months. (This was 5.7 percentage points above the local CCG average and 7.3 points above the England average).

Tackle inequity and promote equality

The staff we spoke with demonstrated an understanding of the impact that deprivation had on patients' health and wellbeing. They spoke clearly of the steps they were taking to meet the needs of patients affected by this. The practice had made suitable arrangements to identify and meet the needs of patients whose circumstances made them vulnerable, for example, patients with learning disabilities and those with complex health conditions. Nationally reported QOF data for 2013/14 indicated the practice had provided recommended care and treatment to these patients. For example, the practice had obtained 100% of the total points available to them for providing care and treatment to patients with learning disabilities. (This was 10.3 percentage points above the local CCG average and 15.9 points above the national average.) Alerts had been added to the medical records of patients with learning disabilities so that clinicians would know prior to a consultation what their needs were.

The practice accepted any patient who lived within their practice boundary irrespective of ethnicity, culture, religion, sexual preference, disability or whether they were homeless. Reasonable adjustments had been made which helped patients with disabilities and patients whose first language was not English to access the practice. The premises had been purpose built to meet the needs of patients with disabilities. For example, there were consultation and treatment rooms, and a reception area, on the ground floor. There was a disabled toilet which had appropriate aids and adaptations. The main doors into the practice opened automatically. The clinical records of patients with disabilities contained an alert to remind staff they might need assistance when in the practice. The waiting area was spacious making it easier for patients in wheelchairs to manoeuvre. The practice had a small number of patients whose first language was not English. Staff had access to a telephone translation service and interpreters should they need this to help them understand patients' needs. In addition to this, one of the partners was able to interpret on behalf of patients who spoke Farsi. However, the practice did not have a hearing loop installed for the use of patients with a hearing impairment.

Access to the service

Appointments were available from 08:30am to 6:00pm five days a week. The practice did not provide extended hours appointments. However, they were participating in an initiative run by local practices to provide patients with better access to extended hours appointment. For example, patients were able to access extended hours appointments over the last Christmas period. Plans were also in place to provide the same level of cover over the forthcoming Easter holiday. We noted that the practice website included no information about their involvement in this pilot or details of how patients could access this service. There was information on the website and in a leaflet explaining how patients could access out-of-hours care and treatment.

Patients were able to book appointments by telephone, by visiting the practice or on-line via the practice website. The practice offered a variety of different appointments,

Are services responsive to people's needs?

(for example, to feedback?)

including routine appointments that could be booked up to one month in advance. Same day urgent appointments with a GP were also available, although the patients we spoke with told us these were difficult to access. Information on the practice website advised patients that a same day appointment could be booked with one of the nurses, without the need to see a GP first. Home visits were provided for patients whose clinical condition indicated this was required. Patients were also able to access emergency advice through the on-call duty GP.

Most patients told us they were treated well and received a good service. The majority of the 41 patients who completed CQC comment cards raised no concerns about access to appointments. However, some of the patients we spoke to on the day of the inspection told us they had experienced difficulties obtaining an appointment and waiting times were too long. Findings from the National GP Patient Survey, published in January 2015, showed patients were more satisfied with some aspects of the services provided, and less so with others. For example, the level of patient satisfaction with access to appointments and appointment waiting times, was lower than the local Clinical Commissioning Group (CCG) and national averages. However, the practice had acknowledged this and was taking action to address these concerns in collaboration with their patient participation group.

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 the contractual obligations for GPs in England. The practice manager was the designated person responsible for handling complaints. Information was available to help patients understand the complaints process. The practice website provided patients with information about how to complain. Information about how to complain was also available within the reception area of the practice, as was a suggestions box.

The practice maintained a record of all of the complaints they had received, how these had been handled and what the outcome of their investigation had been. Seven complaints had been received during the previous 12 months. They had all been investigated and feedback was provided to the complainants. Where the practice had identified they could make improvements, the action agreed had been logged. From the information supplied by the practice we were able to confirm they responded appropriately to concerns raised by patients.

Are services well-led?

(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 patient rights charter which described their key commitments to patients. This included a commitment to work in partnership with patients to achieve the best care possible. The practice provided the inspection team with a clear statement about the services they delivered to the key population groups we looked at. In addition to this, a set of aims and objectives had been agreed and formed part of the practice's Care Quality Commission Statement of Purpose. These included, for example, improving the health of patients by assisting them to live in a more healthy way.

The practice had a development plan which set out their key priorities for 2015/16, and who was responsible for ensuring their delivery. Staff told us they knew and understood what the practice was committed to providing and what their responsibilities were in relation to these aims.

Governance Arrangements

Effective governance arrangements were in place. The practice had a suitable policy regarding their governance arrangements, and this had been recently reviewed. The policy identified the key controls that would be put in place to ensure effective governance arrangements, and identified the GP partner responsible for leading in this area. The policy stated the practice would promote patient involvement and seek feedback from patients on the quality of the services provided. The PPG members we spoke with confirmed the practice supported the work of the PPG, and encouraged and welcomed their feedback. They told us the PPG met regularly and had been invited to contribute to discussions about the planned refurbishment of the premises

The clinical governance policy stated that clinical audits and significant event reporting would be undertaken to help improve patient care and minimise risks to their safety. We saw evidence that clinical audits had taken place. However, the practice manager told us the team could be better at carrying out more non-clinical audits. Appropriate arrangements were in place for delivering evidence-based care and updating practice clinical guidelines to ensure they reflected national and local clinical guidelines. The practice had completed the Department of Health Information Governance (IG) Toolkit, and had attained a satisfactory grade for all aspects of the toolkit they had completed. (The IG Toolkit draws together the legal rules and central guidance and presents them in one place as a set of information governance requirements. Practices are required to carry out self-assessments of their compliance with these requirements.)

An effective system was in place for reporting and learning from significant events. Regular meetings, involving staff at all levels, were held to enable effective decision-making and shared learning to take place. For example, dedicated monthly palliative and Admissions Avoidance meetings were held. Practice meetings also took place monthly.

The practice had made arrangements to monitor its clinical performance. Nationally reported Quality and Outcomes Framework (QOF) data, for 2013/14, confirmed the practice participated in an external peer review with other practices in the same Clinical Commissioning Group (CCG), in order to compare data and agree areas for improvement. For example, the practice manager told us their diagnosis rates were benchmarked with other local practices to ensure the practice was not an outlier. (Peer review enables practices to access feedback from colleagues about how well they are performing against agreed standards.)

Leadership, openness and transparency

There was a well-established management structure and a clear allocation of responsibilities, such as clinical lead roles. All of the staff we spoke with demonstrated a good understanding of their areas of responsibility and were able to describe how they took an active role in trying to ensure patients received good care and treatment. Staff told us they would feel comfortable raising concerns with the practice manager or the GP partners.

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

The practice had made arrangements to actively seek and act on feedback from patients and staff. For example, the practice had employed an external organisation to carry out a comprehensive patient survey in 2014. Patients were invited to complete a Friends and Family Test survey (FFT) following a visit to the practice. Feedback from the January 2015 FFT surveys showed that, out of the 51 responses received, 28 patients indicated they were 'extremely likely' to recommend the practice to family and friends, and 18 said they were 'likely' to do so. Information on the practice

Are services well-led?

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

website included reference to the negative feedback received. For example, some patients had raised concerns about being cut off when contacting the practice by telephone. In response to this, we saw the practice manager had commented that the practice was exploring whether another telephone system would prevent this from happening.

The practice had an active PPG that included seven core members who met regularly. (The main aim of promoting the development of a PPG is to help the practice engage with a cross section of the practice population and obtain their views.) Information about how to join the group was available in the patient reception area and on the practice website. The practice had also recruited a small group of patients that were willing to be consulted regularly by via email about various aspects of the services they received.

The practice gathered feedback from staff through regular staff meetings and the use of staff appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning & improvement

The practice had management systems in place which enabled learning and improved performance. The staff we spoke with told us they had opportunities for continuous learning to enable them to maintain and develop their skills and competencies. They said their personal development was encouraged and supported. Staff said they took part in regular 'time-out' sessions which enabled them to complete the training required for their continuing professional development. The practice demonstrated their strong commitment to learning by providing opportunities for undergraduate medical students to have placements at the practice. Reviews of significant events had also taken place and the outcomes had been shared with staff via meetings and on-line. This helped to ensure the practice improved outcomes for patients through continuous learning.