Dr Law & Partners

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?	Outstanding
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 1 October 2014 as part of our new comprehensive inspection programme.

The overall rating for this practice is good. We found the practice to be good in the safe, caring, responsive and well-led domains and outstanding in the effective domain. We found the practice provided good care to older people; people with long term conditions; people in vulnerable circumstances; families, children and young people; working age people and people experiencing poor mental health.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- The practice recognised that patient satisfaction with access to appointments had fallen over the past year. There was evidence that the practice had made changes to respond to this and on-going monitoring demonstrated that changes still needed to be considered. The practice had been working with the Local Area Team, Clinical Commissioning Group and Patient Participation Group (PPG) to address this issue. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive.
- There were systems in place to keep patients safe from the risk and spread of infection. Systems were in place to monitor and make required improvements.
- Evidence we reviewed demonstrated that most patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at listening to patients and gave them enough time.

We saw several areas of outstanding practice including:

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- The provider had developed a referrals feedback slip to gather information from the hospital physiotherapy department to monitor the appropriateness of their patient referrals.
- The lead nurse at the practice was supported by the GP partners within and outside of the service to take on a leadership role. An example of this is where the lead practice nurse led and chaired the local practice nurse forums to promote best practice in the administration of influenza, pneumonia and shingles vaccinations for older people.

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

The provider should:

- Ensure that all electrical equipment at the practice is safety tested.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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 safe. Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks to patients. The practice had a system in place for reporting, recording and monitoring significant events over time. The GP senior partner and staff we spoke with told us there was a blame free culture within the practice. They told us the practice was open and transparent when things went wrong. There were robust systems in place to protect children and vulnerable adults from the risk of abuse. The practice worked with other services to prevent abuse and to put plans of care in place. Medicines were stored safely. The system that ensured temperature sensitive medicines were stored appropriately was effective. There were systems in place to keep patients safe from the risk and spread of infection. Patients were also protected from unsafe or unsuitable clinical equipment however, some non-clinical electrical equipment had not been safety tested since 2010. Patients were cared for by suitably qualified and trained staff and staffing establishments were regularly reviewed to keep patients safe and meet their needs.

Are services effective?

Outstanding

The practice is rated as outstanding for effective. Our findings at inspection showed systems were in place to ensure that all clinicians were not only up-to-date with both the National Institute for Health and Care Excellence guidelines and other locally agreed guidelines but we also saw evidence that confirmed that these guidelines were influencing and improving practice and outcomes for their patients. We saw data that showed the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group (CCG).

The practice was using innovative and proactive methods to improve patient outcomes. Examples of this included a referrals feedback slip to gather information from the hospital physiotherapy department to monitor the appropriateness of their patient referrals; easy read care plans for patients with learning disabilities; 100% of women were offered long acting reversible contraception when provided with emergency contraception and the lead practice nurse was supported by the practice to take on a leadership role for the development of other practice nurses in the region.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for

Summary of findings

several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. We found the practice had initiated many positive service improvements for their patient population that were over and above their contractual obligations. The practice was supported by a very active Patient Participation Group (PPG) who helped with a number of initiatives to benefit patients. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and CCG to secure service improvements where these were identified. All patients over 75 years were provided with a named doctor for continuity of care and urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded appropriately to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. Staff had received inductions, regular performance reviews and attended staff meetings and 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 people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

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

Families, children and young people

Good

This practice is rated as good for families, children and young people. We saw that the practice provided services to meet the needs of this population group. Staff were knowledgeable about how to safeguard children from the risk of abuse. Quarterly face to face meetings between the GPs, health visitors and midwives were held at the practice to discuss how to manage and support children and families in vulnerable situations. There were effective screening and vaccination programmes in place to support patients and health promotion advice was provided. Information was available to young people regarding sexual health and family planning advice was provided by staff at the practice. The GPs and nurses that we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent when gaining consent to care and treatment. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options.

Working age people (including those recently retired and students)

Good

This practice is rated as good for working age patients. We saw that the practice offered a range of appointments which included

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pre-bookable appointments, same day appointments and telephone consultations. Staff told us that they tried to ensure that patients who were working were able to have an early appointment at 8am whenever possible. The practice offered all patients aged 40 to 75 years old a health check with the practice nurse. Well women and well men checks were available for patients to request. Family planning services were provided by the practice for women of working age. There was evidence that the practice monitored the effectiveness of their family planning service through audit. Following changes in practice identified in these audits, 100% of women were offered long acting reversible contraception when emergency hormonal contraception had been given. This helped to prevent unwanted pregnancies.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. It had carried out annual health checks for people with a learning disability.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for patients experiencing poor mental health. The practice maintained a register of patients who experienced mental health problems. We saw that staff had the knowledge, skills and competencies to assess and respond to their needs. Patients experiencing poor mental health received an annual health review to ensure appropriate treatment and support was in place. The practice worked with the local primary care mental health team to provide appointments at the practice for patients experiencing poor mental health. This enabled patients to receive counselling and treatment in surroundings that were familiar to them and maintained their discretion.

Summary of findings

What people who use the service say

Seventeen of the 18 patients we spoke with on the day of our inspection were complimentary about the care and treatment they received. We reviewed the four patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that comments were overwhelmingly positive. Patients told us the staff were always caring and treated them with dignity and respect. They said the nurses and doctors listened and responded to their needs and they were involved in decisions about their care. Patients told us that the practice was always clean and tidy. Some patients we spoke with on the day of our inspection told us they experienced problems getting through to the practice on the phone to make an appointment. Most patients however told us the appointment system was easy to use and met their needs. The results of the GP Patient survey supported these findings.

The results from the National Patient Survey showed that 98% of patients said that their overall experience of the practice was good and that 90% of patients would recommend the practice to someone new to the area.

Areas for improvement

Action the service SHOULD take to improve

The provider should ensure that all electrical equipment at the practice is safety tested.

Outstanding practice

There were examples of outstanding practice at Dr Law and partners as follows:

The practice had developed a referrals feedback slip to gather information from the local hospital's physiotherapy department to monitor the appropriateness of their patient referrals.

The lead nurse at the practice was supported by the GP partners within and outside of the service to take on a leadership role. An example of this is where the lead practice nurse led and chaired the local practice nurse forums to promote best practice in the administration of influenza, pneumonia and shingles vaccinations for older people.

Dr Law & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The lead inspector was accompanied by two GP specialist advisors and an expert by experience who had personal experience of using primary medical services.

Background to Dr Law & Partners

Dr Law and Partners' practice provides primary medical services to patients living in Burton-on-Trent, Staffordshire. The practice is a two storey purpose built town surgery. There are nine consulting rooms and two treatment rooms. The surgery has its own patient car park with easy access for patients with disabilities. The surgery building is owned jointly by some of the partners. The practice houses attached staff including district nurses, health visitors, midwife and counsellors all of whom provide clinics within the surgery.

A team of six GP partners, one salaried GP, three GP Registrars, six nurses including an advanced nurse prescriber, a practice manager, 10 receptionists and seven administrative staff provide care and treatment for approximately 10,200 patients. There are five female and two male doctors at the practice to provide patients with a choice of who to see. The practice provides an anticoagulation clinic for patients who are on warfarin and need to have their blood monitored on a regular basis. The practice has been a training practice for doctors to gain experience and higher qualifications in General Practice and family medicine since 1992. They do not provide an out-of-hours service to their own patients but they have alternative arrangements for patients to be seen when the practice is closed

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

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

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

Detailed findings

Before carrying out our inspection, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We spoke with the chair of the Patient Participation Group and managers of three care homes where Dr Law & Partners provide care and treatment. We carried out an announced inspection on 1 October, 2014. During our inspection we spoke with three GPs, one GP Registrar, two nurses, three receptionists, the practice manager, three receptionists, a Health Visitor and 18 patients. We observed how patients were cared for. We reviewed four patient comment cards sharing their views and experiences of the practice.

Good

Are services safe?

Our findings

Safe Track Record

Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks to patients. Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. They were aware of the most appropriate person to report their concerns to. We saw that a log of incidents, complaints and significant events had been kept at the practice. We saw they had all been appropriately investigated. We saw that reviews of incidents and significant events over time had been completed to identify if there were any reoccurring concerns across the service.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. They kept records of significant events that had occurred over the last 12 months and these were made available to us. The practice was open and transparent when things went wrong. The GP senior partner and staff we spoke with told us there was a blame free culture within the practice. Clinical staff described to us how learning from significant events was shared with them at a weekly practice based learning session or on an individual basis. We found there was no formal system in place that documented when learning had been shared with clinical and non-clinical staff.

Reliable safety systems and processes including safeguarding

Children and vulnerable adults were kept safe from the risk of abuse because there were safeguarding systems in place. Safeguarding policies were in place and staff knew where to find them. There were two safeguarding leads at the practice and staff knew to go to them for advice and support. All staff had received training on safeguarding children and vulnerable adults at a level appropriate to their role. GPs had received the higher level three safeguarding training to support them in their role. A log containing records of this was made available to us. We asked medical, nursing and administrative staff about their most recent training. Staff knew their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. We saw that safeguarding contact details were easily accessible for staff and displayed in most rooms. We saw that a Disclosure and Barring Service (DBS) check had been completed for all clinical and administrative staff. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults and children. It replaced the Criminal Records Bureau (CRB) check.

The practice worked with other services to prevent abuse and to implement plans of care. We spoke with a Health Visitor on the day of our inspection. They told us that they had quarterly face to face meetings with the GPs to discuss how to manage and support children and families in vulnerable situations. They told us the GPs were approachable and were able to contact them to discuss any concerns they may have.

Patients were kept safe from the risk of abuse during an intimate examination. There was an up to date chaperone policy in place to ensure patients were protected from potential abuse during an intimate examination. Nursing staff were aware of their chaperone responsibilities and some patients confirmed that a chaperone had been offered during an intimate examination. There was one poster on display within the reception area informing patients of their right to request a chaperone. It was not clearly visible and could only be seen when a patient stood at the reception desk.

Medicines Management

Medicines were stored safely. We checked medicines stored in the locked medicine cupboard, fridges and the GP's emergency blue box. We found that they were stored appropriately and were in date. There was a policy that clearly outlined how temperature sensitive medicines, such as vaccines, should be stored to ensure they were fit for purpose. It provided guidance on the action to take in the event of a problem. We saw that this system was effective because it had detected a problem with the temperature of one of the medicine fridges and appropriate action had been taken. Emergency medicines for medical emergencies were available and all staff knew where they were stored. Controlled drugs were not kept at the practice.

Medicines were administered safely. We saw there were signed Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, enabling a nurse to administer a medicine to groups of patients without individual

prescriptions. A member of the nursing staff was qualified as an independent prescriber. They had also completed the Clinical Health Assessment module to provide them with the knowledge they required when prescribing.

The practice had a protocol for repeat prescribing which was in line with General Medical Council (GMC) guidance. This covered how staff that generated prescriptions were trained, how changes to patients' repeat medicines were managed and the system for reviewing patients' repeat medicines.

Cleanliness & Infection Control

There were systems in place to keep patients safe from the risk and spread of infection. There was an appropriate infection control policy available for staff to refer to. We saw that the infection control lead had received appropriate infection control training. An infection control audit had been carried out in May 2014. Several issues had been identified and an action plan put in place. We saw that action had been taken to address the issues and a date of completion recorded. Minor surgery was carried out at the practice. We saw that single use instruments were used and they were in date. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

On the day of our inspection the practice was clean and tidy. Patients we spoke with told us that the reception area and consulting rooms were always clean. They told us that when appropriate, staff wore personal protective equipment such as gloves. Staff confirmed personal protective equipment was readily available and we saw that it was.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that staff had received the relevant immunisations and support to manage the risks of health care associated infections. A legionella risk assessment had been completed in May 2014 and an action plan put in place. We saw that work was being carried out to address the identified issues.

Equipment

Patients were protected from unsafe or unsuitable equipment. Emergency equipment such as a defibrillator was available for use in a medical emergency. We saw that the equipment was checked weekly to ensure it was in working order and fit for purpose. We saw there was equipment at the practice that contained mercury. Mercury is a hazardous substance and is subject to the Control of

Substances Hazardous to Health Regulations 2002. We saw a risk assessment had been carried out and two mercury spillage kits were available to keep patients and staff safe in the event of a mercury spillage. We saw records that demonstrated that clinical equipment had been calibrated and safety checked in July 2014. The practice could not provide evidence that non-clinical electrical equipment had recently been safety checked. Some electrical equipment had not been safety tested since 2010.

Staffing & Recruitment

Patients were cared for by suitably qualified and trained staff. We saw evidence that health professionals, such as doctors and nurses, were registered with their appropriate professional body and so considered fit to practice. There was a system in place that ensured health professionals' registrations were in date. There was a recruitment policy in place and we saw that it met the requirements of our regulations. We looked at the records of three members of staff and saw that appropriate recruitment processes and checks had been carried out before staff started to work at the practice. There were clearly defined staffing rotas and systems in place to cover annual leave.

Monitoring Safety & Responding to Risk

Staffing establishments were reviewed to keep patients safe and meet their needs. Where staffing issues had been identified, we saw that action plans were in place outlining how risks would be managed and work re-allocated. We saw that the practice population size of the practice had been continually increasing. An appointments audit had been carried out in February, March and May 2014 which highlighted the increased demand for appointments with GPs. To help to meet this demand, a GP had been employed to provide an additional five sessions per week. There were systems in place to deal with busy periods and staff shortages. The practice had a business continuity plan in place that contained a risk assessment and an action plan detailing how the practice would respond to busy periods such as the increase demand for appointments in winter.

Maintenance of the premises was designed to keep patients safe. We saw there was subsidence and cracks in the plaster at the practice. We were shown risk

assessments, action plans, quotes and timeframes for the repair work to be completed. A fire risk assessment and asbestos management plan had been completed which confirmed that the building was safe.

Arrangements to deal with emergencies and major incidents

There were systems in place to deal with medical emergencies. We saw records demonstrating that staff were trained in cardiopulmonary resuscitation (CPR) and when they would be due for an update. Staff we spoke with confirmed they had received CPR training and appropriately described the care they would provide to patients in the event of a medical emergency. There were emergency drugs, a defibrillator, oxygen, pulse oximeters and airway maintenance equipment for adults and children available at the practice. There were systems in place to ensure that the emergency drugs and oxygen were in date and that the emergency equipment was fit for purpose.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients' needs were assessed and care and treatment delivered in line with current evidence based guidance. We saw electronic records demonstrating that clinical staff had access to the National Institute for Health and Care Excellence (NICE) guidelines. Clinical staff described to us how they used these to assess the needs of their patients. For example, we saw that changes to the guidance for the prescription of statins (medicines that can help to lower cholesterol levels in blood) had been followed. We saw minutes of practice meetings where new guidelines were disseminated and the implications for the practice's performance and patients were discussed. All the GPs interviewed were aware of their professional responsibilities to maintain their knowledge.

The practice referred patients appropriately to secondary and other community care services. National data showed the practice had a high referral rate to ophthalmology, general surgery and trauma. The practice told us they were investigating why this was and what they could do to reduce it. We saw that the practice was proactive and had developed a referrals feedback slip to gather information from the physiotherapy department regarding the appropriateness of their referrals. An analysis of the feedback slips was ongoing.

Patients with long term conditions received an annual needs assessment. We saw that an audit had been carried out on blood test requests for routine long term conditions such as high blood pressure or diabetes. The audit identified that the blood tests requested varied amongst GPs. As a result of the audit a proforma had been developed that standardised which blood tests were appropriate and effective for patients with a stable long term condition.

Patients with a learning disability received an annual health assessment using the Cardiff Health Check template. We saw that the assessment was carried out by a practice nurse who had completed a health assessment module. A GP buddying system was in place if the nurse required additional support or advice. At the end of the review we saw that the patient was provided with a health action plan which was agreed with them. Information inviting them to the assessment and the health action plan were provided in an easy read format ensuring that the method of communicating with patients with learning difficulties was effective and met their needs. There were systems in place that ensured babies received a new born and eight week development assessment. A GP told us that patients with mental health difficulties received an annual health review. We saw there was a care plan template to enable GPs to plan the care for patients with mental health difficulties. GPs we spoke with were able to describe how this template was applied during a patient's assessment. Every patient over 75 years had a named GP and each of the 14 care homes had a named GP. We spoke with representatives from three of the 14 care homes the practice provided care and support to. They confirmed that needs assessments were completed when required. The senior GP partner told us that they were exploring the introduction of weekly ward rounds within the care homes to ensure that older patients' needs were assessed and monitored effectively. The representatives from the homes we spoke with confirmed this had been discussed with them.

Staff told us there was a high turnover of temporary residents registered with them at one time. This was due to a nearby housing association that accommodated temporary residents and a nearby residential drug and alcohol addiction centre. The practice informed us that they had a policy to accept homeless patients and any patient who lived within their practice boundary irrespective of race, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). The QOF rewards practices for providing quality care and helps to fund further improvements. We saw that there was a robust system in place to frequently review QOF data and recall patients when needed. The practice participated in a benchmarking process with other practices within East Staffordshire Commissioning Group (CCG). This allowed practices to compare their performance against other practices in the CCG in areas such as referrals to A&E. We saw minutes demonstrating that the GP who attended these meetings shared the information with the other staff at the practice.

The practice had a system in place for completing clinical audit cycles. The practice showed us 10 clinical audits that

had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding the use of simvastatin (a medicine used to reduce blood cholesterol levels) a clinical audit was carried out by the practice. The aim of the audit was to ensure that all patients prescribed simvastatin were not put at risk of serious drug interactions. The first audit demonstrated that 187 patients were not receiving the revised dose of simvastatin. The information was shared with GPs and patients were called for a medication review. A second clinical audit was completed one year later which demonstrated that only one patient was not receiving the new recommended dose.

The practice had taken on the enhanced service for the avoidance of unplanned hospital admissions. Enhanced services are additional services provided by GPs to meet the needs of their patients. To meet this objective they have recently completed 170 care plans for elderly patients. We spoke with representatives from three of the 14 care homes the practice provided care and support to. They confirmed that care plans had been put in place and the care that the practice provided was of a high standard. They told us they had a good working relationship with the practice and that the practice responded quickly to any concerns they had about patients. Every patient over 75 years of age had a named GP and each of the 14 care homes had a named GP to ensure continuity of care and to develop relationships between the GP and care home staff. The practice had 23 patients on their end of life register. We saw minutes from multi-disciplinary meetings between GPs, palliative care nurses and district nurses that demonstrated care plans for patients near the end of their life were reviewed on a regular basis. The practice used special notes to ensure that the out of hours service were also aware of the needs of these patients when the practice was closed.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The practice manager, a lead GP and lead practice nurse were responsible for staff training. The practice was a training practice for GP registrars. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. There was a comprehensive induction programme in place to support new doctors into the practice. A GP registrar we spoke with told us they felt very supported at the practice. They told us they valued the GP buddying system which provided them with a daily named GP they could go to for advice and support. The senior GP partner told us that they had been asked by the Deanery of the local university to support two GP registrars who required additional support. The GP registrars went on to successfully complete their training. GPs we spoke with told us they were supported in their revalidation through an appraisal system. Revalidation is the process by which licensed doctors are required to demonstrate that they are up to date with current best practice and fit to practise.

A management task planner was in place for 2014-2015 which identified when staff appraisals and training were due. We looked in the records of three recently recruited members of staff and saw that they had all received an induction to the practice, completed an appraisal within the last year and identified their training needs. Staff we spoke with all confirmed they received an annual appraisal. Where staff had identified the need for additional training specific to their role or for their professional development, staff told us they had been supported to access this. The practice manager showed us a training log that identified what training staff had completed, when they had completed it and when it needed to be repeated. Continual clinical development and supervision was supported through a weekly one hour practice based learning session within the practice. We saw evidence that these sessions included such areas as reviewing significant events and audit or guest speakers. All staff were provided with one hour of protected learning time each week to enable them to access online training.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. We saw, and a Health Visitor confirmed, that quarterly meetings between GPs, Health Visitors and midwives were held to discuss, assess and plan care around safeguarding concerns. The practice held multidisciplinary team meetings to discuss the needs of patients with end of life care needs. Minutes from multi-disciplinary meetings between the practice, palliative care nurses and district nurses demonstrated that patients who were receiving end of life care were provided with appropriately co-ordinated care. We saw that the practice used special notes to ensure that the out of hours service were also aware of the needs of these patients

when the practice was closed. We saw that the practice worked with the district nursing teams and community matrons to assist in the provision of long term condition monitoring and management of care for housebound patients. The practice worked with the local primary care mental health team to provide appointments at the practice for patients experiencing poor mental health.

Information Sharing

There was a system in place for receiving, managing, reviewing and following up the results of tests requested for patients. Reception staff we spoke with clearly understood their role and responsibilities in handling these results and who the results were to be shared with. Blood and X-ray results were received electronically and reviewed by a GP on a daily basis. The GP who reviewed the results was responsible for taking the appropriate action. The practice used special notes to ensure that the out of hours service were also aware of the needs of patients receiving end of life care when the practice was closed. The practice was in the process on putting patient care plans on to the special notes system so that the out of hours service were aware of patients' needs.

Hospital discharge, A&E, outpatients and discharge letters were received in paper format. Once the practice received the letters they were allocated to the most appropriate doctor and followed up the same day.

Consent to care and treatment

There were mechanisms to seek, record and review consent decisions. We saw there were consent forms for patients to sign agreeing to minor surgery procedures. We saw that the need for the surgery and the risks involved had been clearly explained to patients. We saw a minor surgery audit for 2013–2014 had been carried out at the practice which included consent to treatment. The audit demonstrated that 100% of minor surgery procedures carried out on patients had written consent in place.

We saw signed consent forms for children who had received immunisations. The practice nurse was aware of the need for parental consent and what action to follow if a parent was unavailable. There were leaflets available for parents informing them of potential side effects of the immunisations. The GPs and nurses that we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options. The practice had access to interpreting services to ensure patients understood procedures if their first language was not English.

Some staff we spoke with had not received training in the Mental Capacity Act 2005 but demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. We saw examples of how young people, patients with a learning disability, mental health difficulty or dementia were supported to make decisions. For example, there were easy read leaflets and health action plans to enable patients with learning difficulties to understand their planned treatment and care. When patients did not have capacity the staff we spoke with gave us examples of how the patient's best interest was taken into account.

When a person does not wish to be resuscitated in the event of severe illness a 'Do not attempt resuscitation' (DNAR) form is completed to record this in their records to protect them from the risk of receiving inappropriate treatment. We spoke with a representative from three care homes that the practice provided care and support to. They confirmed that DNARs were reviewed by GPs from the practice and that GPs reviewed new DNARs that had been put in place whilst a patient was in hospital.

Health Promotion & Prevention

The practice offered all new patients registering with the practice and patients aged 40 to 75 years old a health check with the practice nurse. Well women and well men checks were available for patients on request. The practice nurse carried out weekly vaccination sessions for children in line with the Healthy Child Programme. We saw that the percentage of children who had received the appropriate vaccination at the appropriate time ranged from 90 to 100% which was in line with the Clinical Commissioning Group (CCG) regional average. A travel vaccination programme was also carried out at the practice which included the vaccination for yellow fever.

Family planning services were provided by the practice for women of working age. Three clinical audit cycles had

Outstanding ☆

Are services effective?

(for example, treatment is effective)

been completed exploring the percentage of women who had received long acting reversible contraception (LARC) when emergency hormonal contraception had been given. The first audit cycle demonstrated that 83% of women had been provided with LARC. Following a raise in awareness amongst clinical staff and the introduction of information packs in consulting rooms, the third clinical audit cycle demonstrated that 100% of women were offered LARC to prevent unwanted pregnancies. All six of the practice nurses were trained in performing cervical smears and Chlamydia screening kits were available in the toilets for young patients to access discreetly. Condoms were also available free on request.

The practice nurses offered healthy living advice and support to patients. This included referrals to weight watchers and council physical activity exercise classes for patients who needed a weight management programme. We saw that one of the council exercise classes was specifically for women from the black minority ethnic population group. All patients with a learning disability were offered an annual physical health check and provided with healthy living advice leaflets in an easy read format.

Flu vaccination was offered to all patients over the age of 65, those in at risk groups and pregnant women. The shingles vaccination was offered according to national guidance for older people.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from 126 patients who took part in the GP patient survey. The GP patient survey is an independent survey run by Ipsos MORI on behalf of NHS England. We also reviewed data from a survey of 526 patients undertaken by the practice's Patient Participation Group (PPG). PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The evidence from these sources demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey showed that 98% of patients described their overall experience of this practice as good or very good. This was 10% above the Clinical Commissioning Group (CCG) regional average. Ninety-four per cent of practice respondents said the GP was good at listening to them and 96% said the GP gave them enough time. All these scores were above the CCG regional average.

Patients completed CQC comment cards to provide us with feedback on the practice. We received four completed cards and all were positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were friendly, helpful and respectful. They said staff treated them with dignity and respect and never patronised them. We also spoke with 18 patients on the day of our inspection. Seventeen out of the 18 patients we spoke with told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We saw that consultation treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private.

Patients we spoke with on the day of our inspection confirmed that they had never overheard anything confidential at the reception desk. The practice switchboard was located upstairs away from the reception desk so telephone conversations could not be overheard.

The practice told us that they had a high turnover of temporary patients registered with them at one time. This was due to a nearby housing association that accommodated temporary residents and a nearby residential drug and alcohol addiction centre. The practice informed us that they had a policy to accept homeless patients and any patient who lived within their practice boundary irrespective of race, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. We saw an example where the practice had actioned this policy following an incident.

Care planning and involvement in decisions about care and treatment

The GP 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 81% of practice respondents said the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and results. Both these results were above average compared to the CCG regional average.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. One of the GP partners offered alternative therapies for patients who preferred non-invasive, drug free pain relief treatment. Staff told us that translation services were available for patients who did not have English as a first language.

Good

Are services caring?

There were 80 patients on the practice's learning difficulties register. We saw that annual health reviews were carried out for patients with learning difficulties using the Cardiff Health Check template. At the end of the review the patient was provided with a health action plan which was agreed with them. We saw two examples where the health action plan was provided in an easy read format so that patients understood it. There were 68 patients on the practices' register for patients with mental health difficulties. There was a system in place to ensure that patients with mental health difficulties received an annual health review. We saw there was a care plan template to enable GPs to plan the care for patients with mental health difficulties. The staff told us that the recall system for patients with long term conditions, such as diabetes or high blood pressure, had recently been updated. Patients were called for a review of their care and treatment on their birthday and were provided with an extended appointment at a time convenient for them. Changes to the recall system for annual reviews were clearly communicated to patients through the patient newsletter.

Patient/carer support to cope emotionally with care and treatment

The GP patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it good or very good in this area. For example, 92% of patients surveyed said the last GP they saw or spoke to was good at treating them with care and concern with a score of 82% for nurses. These results were above the CCG regional average. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, patients described the care they received as excellent and of a higher standard than other practices they had previously been registered with.

Notices in the patient's waiting room and on the practice website sign posted patients to a number of support groups and organisations. The practice provided support for carers and had developed a carer's register working with the Carers Association for South Staffordshire (CASS). We saw that GPs had access to electronic leaflets that they printed off to provide advice and support to carers regarding certain conditions. The practice website provided a direct link to the carer's association which provided financial and practical advice and applications to the carer's health respite break fund.

Staff told us families who had suffered bereavement were called by their usual GP and offered a GP consultation if required. However, patients we spoke with on the day of inspection who had suffered bereavement told us they had not received this support. Some staff were also unclear of where to direct patients to for bereavement support and there were no information leaflets on display in the reception area

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to patients' needs and had sustainable systems in place to maintain the level of service provided. The practice was innovative and willing to take on new approaches to meet the needs of their patients. We saw that the practice offered an anti-coagulation monitoring and dosing clinic for patients on warfarin (a medicine that is given to stop clots forming in the blood). A practice nurse led the clinic and was supported by a GP through the practice's buddying system. The clinic supported up to 75 patients removing the need for them to travel to the hospital and provided patients with their test results immediately. The practice had also opted into the Flo hypertension monitoring system which enabled patients to monitor their own blood pressure using a text messaging service. This included a 20 minute patient education session and the loan of a blood pressure monitoring devise. The patient texted their results to Flo. The GP analysed the results weekly and responded with the appropriate advice. This system ran alongside the practice's own system for monitoring high blood pressure and offered choice to patients who preferred to use text messaging as part of their management.

The needs of the practice population were understood and systems were in place to address identified needs. The NHS Local Area Team (LAT) and Clinical Commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. This included A&E referrals and the introduction of an urgent care dashboard. The dashboard provided practices with the facility to identify frequent attenders to A&E. The use of special notes when sharing information between the practice and the out of hours service was also discussed and plans put in place to support practices in the use of this service.

The practice had an active Patient Participation Group (PPG) to help it to engage with a cross-section of the practice population and obtain patient views. We spoke with the chair of the PPG who explained their role and how they worked with the practice. They told us there was a regular membership of 14 patients with an age range of 30 to 60 years. PPG meetings were held on a monthly basis and the minutes were available on the practice's website. The practice had implemented many suggestions for improvements and made changes to the way it delivered services as a consequence of the PPG feedback. These included the introduction of text messaging to remind patients when their appointment was and the management of patients who regularly failed to attend for their appointment.

The practice had achieved and implemented the gold standard framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients and their families' care and support needs. As a consequence of staff training and better understanding of the needs of patients, the practice had 23 patients on their end of life register. The practice had developed a personalised care pathway for the care of the dying patient which involved advanced planning and symptomatic support. It was supported by an end of life policy and a palliative care policy and protocol.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. The practice staff told us there was a nearby housing association that accommodated temporary residents. They told us there was also a nearby residential drug and alcohol addiction centre. The practice had a policy to accept patients living in these areas as a temporary resident to ensure they had access to primary medical services during their time there. The practice informed us they had a policy to accept homeless patients and any patient who lived within their practice boundary irrespective of race, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

Patients with learning difficulties were provided with an annual health review and health advice leaflets in an easy read format. The primary care mental health team offered appointments at the practice. This enabled patients with mental health difficulties to receive counselling and treatment in surroundings that were familiar to them and maintained their discretion. The practice had completed 170 care plans for some of their most vulnerable patients. The majority of these patients were elderly and included all

Good

Are services responsive to people's needs?

(for example, to feedback?)

their patients in care homes as well as housebound and mobile elderly patients. Representatives from three of the care homes confirmed care plans had been put in place with the agreement of the patient.

We saw that the premises and services met the needs of patients with disabilities such as hearing and mobility difficulties. We saw there were baby changing facilities and that breast feeding mothers were offered a private room in which to feed their babies.

The practice population was 91.5% British or mixed British. Whilst the majority of the practice population were English speaking there was a four per cent eastern European population which was increasing. Staff told us they had access to a telephone translation service if a patient did not speak English.

Access to the service

The practice opened 8am until 6pm Monday to Friday. The practice opened from 8am to accommodate working age patients. It was closed from 12.30pm until 1.30pm on Thursdays for staff training. Appointments could be booked up to four weeks in advance, by telephone or face to face. There were also a limited number of online appointments available. Emergency appointments were provided on the day or the GP rang the patient back. Six of the 18 patients we spoke with told us that getting through on the telephone to book an appointment could be difficult however, 15 of the 18 patients we spoke with told us they were satisfied with the timing of the appointments they received.

The practice told us the demand for appointments was continually increasing with patients transferring from other practices. They recognised that patient satisfaction with access to appointments had fallen from excellent to difficult in the latest GP patient survey. They showed us a summary of four appointment audits that had been carried out throughout 2014. We saw changes to the ratio of on the day and pre-bookable appointments had been made to try to meet patients' requirements. Changes to the practice boundary had also been trialled and text messaging reminders introduced. A robust system had been put in place to address patients who constantly failed to attend for their appointments. The practice informed us there would be on-going monitoring and that they had been working with the PPG, LAT and CCG to address this issue. Spokespersons for these groups confirmed they had.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of hours service. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients on the practice's website, in the patient's practice guide and displayed in the reception area.

There were arrangements to ensure that care and treatment was provided to patients with regard to their disability. There was a hearing loop system available for patients with a hearing impairment and clear signage informing patients where to go. There was a wheelchair available for patients with mobility problems, a disabled toilet and disabled parking spaces. Consulting rooms were situated on the ground floor of the practice making rooms easily accessible for patients. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. We saw their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. Patients were made aware of how to complain by a poster in the reception area, through the practice's website and information in the practice leaflet. Reception staff informed us they tried to deal with complaints at source and informed the practice manager immediately. We looked at the practice's complaints register for 2013-2014 and saw they had received 19 complaints. We saw that all complaints had been investigated, analysed and responded to in a timely manner. Where learning had taken place there was a system in place to share learning with staff members.

Staff told us that there was an open and transparent culture in place and their concerns were listened to. We saw there was a whistleblowing policy in place. Staff we spoke with were aware of why whistleblowing was important and who to go to if they had any concerns. They were also aware of where to locate the policy if they needed to refer to it for support

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. There had been several staff changes at the practice over the previous year but the management team were in the process of considering their three to five year business plan. The practice values were clearly displayed in the waiting areas, in the staff room, on their website, in their patient charter and patient practice guide. It stated, 'Our aim is to offer the best personal care to you and your family'.

We spoke with 13 members of staff and they all understood and demonstrated the vision and values and knew what their responsibilities were in relation to these. The practice's strategy to achieve their vision placed a high emphasis on supporting staff through education, training and embracing new and innovative ideas. We saw that progress against delivering this was monitored and reviewed at the GP partner's business meeting. We looked at the minutes from this meeting which included monitoring of education and training; finance; commissioning and federation; staffing and personal; information technology and communication; contract arrangements and clinical governance. We saw there was system in place whereby the lead practice nurse and the practice manager shared updates from the nursing and administrative teams.

Governance Arrangements

There was an effective governance framework in place to support the delivery of good quality care. The practice had invested in a governance system. The system contained around 170 policies which could be download and adapted to meet the practices' needs. We saw that the practice had downloaded the appropriate policies for its service and adapted them to reflect the needs of their patients. The practice manager and senior GP partner told us this ensured that all areas of service delivery followed best practice and were up to date. The practice manager had a management task planner in place for 2014-2015 which identified when each policy was due to be reviewed. We saw that policies had been reviewed in line with the task planner. Staff we spoke with were aware of where to locate the policies if they needed to refer to them for support or guidance.

The practice held weekly business meetings and six weekly partners' meetings. The practice manager held regular meetings with the administrative staff and the lead nurse held regular team meetings with clinical staff. We looked at minutes from the last partner's meeting which contained updates from the nursing and administrative meetings. We saw that performance, quality and risks had been discussed.

The practice held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract, quality and performance was monitored using the Quality and Outcomes Framework (QOF). The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. We looked at the QOF data for this practice which showed it was performing in line with national standards scoring 99.4 out of a possible 100 points.

The practice used clinical audit to monitor quality and systems to identify where action needed to be taken. The practice had completed a number of clinical audits, for example the prescribing of Strontium Ralenate, a medicine used in the treatment of osteoporosis. Following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) relating to Strontium Ralenate and cardiovascular safety the practice reviewed all patients prescribed this medicine to consider whether or not to continue treatment. The first audit cycle identified that eight patients were receiving this medication. All patients were called in for a review of their medication. A second audit cycle identified that all the patients had received a medication review and their prescription stopped where clinically indicated and replaced by an alternative.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as Control of Substances Hazardous to Health (COSHH), asbestos, fire safety, buildings maintenance, access to appointments and prevention of the legionella virus. We saw that the risks were regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, we saw there was subsidence and cracks in the plaster at the practice. We were shown

Are services well-led?

Good

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

risk assessments, action plans, quotes and timeframes for the repair work to be completed. A fire risk assessment and asbestos management plan had been completed which confirmed that the building was safe.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example there was a lead nurse for infection control, a GP lead for training and development and a GP lead for safeguarding. We spoke with 13 members of staff and they were all clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The lead nurse at the practice was also the chair of the local practice nurses' forum. The lead practice nurse was not available to speak with on the day of our inspection. Another nurse at the practice told us that they and practice nurses from other practices found this forum informative, supportive and provided peer review. We looked at the minutes from the last forum which showed that current issues were discussed and the opportunity to compare best practice between services was provided. For example, with the approach of winter, updates and discussion had taken place regarding vaccinations for influenza, pneumonia and shingles. The GP partners told us they recognised the leadership role their lead practice nurse held within and outside of the practice and were committed to supporting her. The lead nurse at the practice also sat on the regional practice nurse panel and had promoted student nurse placements in general practice.

We saw minutes that demonstrated that meetings such as team, business and partners' meetings were held on a regular basis. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

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

Feedback and comments by staff were encouraged, listened to and acted upon. The practice actively encouraged the participation and involvement of staff through annual appraisals. Team meetings were held for staff and they were encouraged to add items to the agenda that they wished to discuss. Staff told us they felt involved and listened to within the practice. There was a whistleblowing policy available for staff at the practice and staff we spoke with understood what whistleblowing was and why it was important. Whistleblowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected.

The practice recognised the importance of the views of patients and had systems in place to do this. This included the use of patients' comments, analysis of complaints, patient surveys and working in partnership with the Patient Participation Group (PPG). Results of patients' surveys and PPG comments were shared with patients through the practice website. We saw that the PPG had developed an action plan and the practice had worked with the PPG to carry out the issues within the action plan. The chair person for the PPG confirmed that they had a very good working relationship with the practice and that the partners were open and honest and listened to what they said.

Management lead through learning & improvement

The practice had been a GP training practice for qualified doctors to become general practitioners since 1992. The ethos of learning and improvement in terms of knowledge and skills was evident throughout the inspection. There was a lead GP responsible for the induction and overseeing of the GP registrar's training. We spoke with a GP registrar who told us there was strong leadership within the practice. There was a buddying system in place to support GP registrars that provided them with a named GP who they had direct access to for advice and support. The senior GP partner told us that they had been asked by the deanery of the local university to support two GP registrars who needed additional support to complete their GP training. The GP registrars went on to successfully complete their training.

We were shown evidence that staff in all roles were provided with a thorough induction process. We saw that staff had access to a range of training opportunities. We looked at records which showed that all staff training was up to date. The lead practice nurse had completed an extended nurse prescriber's course alongside a health assessment module. This had enabled them to lead in areas such as health reviews for patients with learning difficulties. The practice had reviewed the effectiveness of these additional skills and had committed to supporting another practice nurse through the extended nurse prescriber's course.

Are services well-led?

Good

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

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place. Staff told us that the practice was very supportive of training and that they had weekly practice based learning sessions which included such issues as learning from audits and complaints and guest speakers from outside of the practice. We saw there was a meeting schedule for the whole of the year which was clearly displayed in the staffroom. Staff were also provided with protected learning time each week to ensure that their mandatory training was up to date. The partners from the practice valued learning and improvement and we saw that this had a regular agenda item in the partner's business meetings.

The practice had completed reviews of significant events and other incidents. There was no system in place for recording when learning had been shared with staff but the senior GP partner told us staff were informed via meetings and on a one to one basis. For example, we saw a patient had become very aggressive towards a member of staff. We saw that appropriate action was taken by the practice to protect other staff. The practice informed us that staff had been reminded of procedures to follow in the event of this reoccurring.