Chapel Street Medical Centre

Quality Report

87 Chapel Street
Lye
Stourbridge
West Midlands
DY9 8BT87
Tel: 01384 897668
Website: www.chapelstreetsurgery.nhs.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Chapel Street Medical Centre on 20 January 2015. We rated the practice as good overall.

Specifically, we found the practice to be good for providing effective, caring, responsive and well-led services. It was also good for providing services for the six population groups. It required improvement for providing a safe service.

Our key findings across all of 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.
- The management of risks to patients was not robust. Some risks to the practice had been identified and addressed, but we found a number of areas during our inspection in which risks identified had not been appropriately assessed and acted on such as the provision of appropriate emergency equipment and medicines and legionella testing.
- Patients' needs were assessed and care was planned and delivered according to best practice guidance. Staff had received training appropriate to their roles and further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect, although patients felt being involved and making decisions about their care treatment was an area for improvement.
- Information about services and how to complain was available and easy to understand but was not clearly displayed in the practice.
- Most patients said they found it easy to make an appointment with a named GP, urgent appointments were available on the same day. However, feedback from patients indicated patients were not satisfied with the practice opening hours.
- The practice had adapted the premises to ensure disabled patients could access the service. Facilities were also available for those with young children.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. However, there were areas the practice needed to improve on such as the management of risks including those relating to patient satisfaction.

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

The provider should:

- Ensure that robust and effective systems are put in place to protect patients from the risks of unsafe care such as not having certain emergency equipment and medicines and the absence of legionella testing.
- Ensure audits complete their full audit cycle in order to demonstrate improvements made to practice.
- Review how the service can improve patient satisfaction in relation to involvement in care, treatment decisions and accessibility to the practice in relation to opening hours and appointments.
- Ensure all staff who act as chaperones have a DBS check or should be risk assessed as to whether a DBS is needed.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not always sufficiently thorough to mitigate against future reoccurrence. Information about safety was recorded, monitored, appropriately reviewed and addressed. We saw that some risks to patients had been identified and managed for example fire risks and checks to ensure suitable staff were employed. Howerer, we highlighted risks in relation to the availability of emergency equipment and medicines and legionella that had not been addressed.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes for most long term conditions were in line with other practices in the locality and those that were not were being addressed. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely when delievering care and treatment. Patient's needs were assessed and care was planned and delivered in line with current best practice . This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. There was evidence of appraisals and personal development plans for staff. Staff worked with multi-disciplinary teams.

Are services caring?

Good

The practice is rated as good for providing a caring service. Data showed that patients rated the practice in line with others for several aspects of care. Patients said they were treated with compassion, dignity and respect. However, patient involvement in decisions about their care and treatment as an area for improvement. 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 providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment and that there was continuity of care. Data available indicated that patients

Summary of findings

were generally not satisfied with opening hours. The practice had adapted the premises to support patients with a disability or young children to access the service they needed. Information about how to complain was available and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders took place.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice did not have a clear vision for its future although staff were aware of the importance of providing a good service 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 risks although the practice should review the management of some of the risks identified. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active although there were few members. 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 such as chronic obstructive pulmonary disease (COPD), cancer and heart failure. Where the practice was performing less well compared to the local clinical commissioning group (CCG) action had been taken to improve outcomes for these patients although further work was still needed. The practice offered proactive, personalised care to meet the needs of the older people and had introduced a range of enhanced services, for example, in the area of dementia and end of life care. It was responsive to the needs of older people, offering health reviews to patients over 75 years and home visits. Data from the year 2013 to 2014 showed a good uptake of flu vaccinations from this section of the population. Patients who needed urgent appointments would be seen or consulted with by telephone on the same day.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and were trained to do so. Data showed the practice performed well in the management of most long term conditions against the local clinical commissioning group (CCG) average. Diabetes had specifically been recognised as an area for improvement and action had been taken through multi-disciplinary team work to improve outcomes for these patients. Longer appointments and home visits were available when needed. Patients with long term conditions had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health care professionals to deliver a multi-disciplinary package of care. The practice followed up patient who had unplanned admissions as part of an enhanced service (services provided above the standard GMS contract). A range of health promotion information was available for various long term conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of

Summary of findings

A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. Children toys, baby changing facilities and breast feeding friendly service was available. The midwife and health visitor held regular clinics from the practice which facilitated joint working.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified. The practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Extended opening hours and telephone consultations helped to accommodate patients who worked. The practice had a high proportion of patient that travelled abroad and offered travel vaccinations to accommodate this. The practice offered NHS health checks to patients of working age to help identify any early onset of disease. A range of health promotion information was available. The practice also offered chlamydia screening to younger adults at the practice.

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 such as those with a learning disability and vulnerable adults. It had carried out annual health checks for people with a learning disability. Patients who needed longer appointments were able to access this.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had a high proportion of patients of British Pakistani origin who were supported well in the community. They had developed a good working relation with the social worker who worked from the local mosque . The social worker was able to direct vulnerable patients to appropriate support services available to them. Carers were also identified and referred for assessment to identify the support available to them.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health were invited for a health review. Of the 15 patients on the mental health register 13 had been reviewed in the last 12 months and had care plans in place. Data available showed the practice performed better than other practices in the local clinical commissioning group (CCG) for the management of patients with poor mental health. The practice had a community psychiatric nurse who worked from the practice who the GPs could refer patients to.

Data available showed the practice performed less well than other practices in the CCG area for the care of patients with dementia. In response to this the practice had signed up to the dementia enhanced service in order to identify dementia at an earlier stage. The practice now had a dementia register and were implementing a dementia protocol to identify patients so that appropriate care could be given.

From training records seen staff had not received any specific training in the care of patients with mental health issues or dementia.

Summary of findings

What people who use the service say

As part of the inspection we spoke with four patients registered at the practice. We also sent the practice comment cards prior to the inspection inviting patients to tell us about the care they received. We received 12 completed comment cards.

Our discussions with patients and feedback from the comment cards indicated patients were happy with the service that they received at the practice. Patients described the service as good and they told us staff were friendly. They told us that they were treated with dignity and respect. Although, comments received indicated that patients were satisfied overall with the practice five patients commented on the difficulty making appointments which mostly related to getting through to the practice or waiting too long to be seen.

We also looked at data available from the national GP patient survey and in house practice survey. Results from the national patient survey found that practice opening hours, involvement in care and treatment decisions and recommending the practice as areas for improvement. The practice had taken some action but further work was required to improve these area.

We spoke with a member of the patient participation group (PPG). PPGs are a way for patients and GP surgeries to work together to improve the service and to promote and improve the quality of the care. They told us that the practice had an active patient participation group that met regularly. The PPG member was satisfied that the group was listened to and that action was taken in response to issues raised at the meetings.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that robust and effective systems are put in place to protect patients from the risks of unsafe care such as not having certain emergency equipment and medicines and the absence of legionella testing.
- Ensure audits complete their full audit cycle in order to demonstrate improvements made to practice.
- Review how the service can improve patient satisfaction in relation to involvement in care, treatment decisions and accessibility to the practice in relation to opening hours and appointments.
- Ensure all staff who act as chaperones have a DBS check or should be risk assessed as to whether a DBS is needed.

Chapel Street Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector supported by a GP specialist advisor.

Background to Chapel Street Medical Centre

Chapel Street Medical Centre is registered to provide primary medical services with the Care Quality Commission (CQC) and is located in Stourbridge in the West Midlands in a converted house. The practice has a registered list size of approximately 1900 patients. It is located in an area with high levels of deprivation and is among one of the most deprived areas nationally. It is part of NHS Dudley CCG Clinical Commissioning Group (CCG).

The practice consists of two GP partners, one male and one female. There is also a practice nurse (female), a practice manager (who works part time) and three reception staff. The senior receptionists also undertakes many duties in the management of the practice.

The practice holds a General Medical Services (GMS) contract to deliver essential primary care services.

The practice is open Monday to Friday 9.30am until 12.30pm and 5.00pm until 7.00pm except Wednesday when it closes for the afternoon. Appointments are available between 9.30am to 11.30am and 5.00pm to 6.30pm daily except on a Wednesday. Extended opening hours are available on Tuesday and Thursday evenings between 6.30pm and 7.00pm. When the practice is closed during the day patients are able to contact the GP through another provider who handles calls. During the out of hours period (6.30pm and 8.00am) patients receive primary medical services through another provider (Primecare).

Why we carried out this inspection

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

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

How we carried out this inspection

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:

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 that we hold about the practice and asked other organisations to share what they knew about the service. We carried out an announced inspection on 20 January 2015. During our visit we spoke with a range of staff (including a GP, prescribing advisor, practice nurse, practice manager and two reception staff) and looked at a range of documents that were made available to us relating to the practice, and patients care and treatment. We sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 12 completed cards where patients shared their views and experiences of the service. We also spoke with four patients in person who used the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and would report incidents and near misses to the senior receptionist who would complete and manage the relevant documentation. For example where an incorrect vaccine had been issued and administered to a patient, advice had been sought and the situation corrected.

We reviewed minutes of meetings and saw that incidents were routinely discussed and the evidence showed the practice could evidence a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events dating back to 2004 and we were able to review these. Significant events were a standing item on the practice meeting agenda where actions from past significant events and complaints were reviewed and learning was shared with all staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Incident forms were available to staff on the practice intranet. Staff spoken with were aware of the relevant forms but told us that they would usually notify the senior receptionist who would complete them. We tracked three incidents that had occurred in the last 12 months. We saw records were completed in a timely manner with evidence of immediate action being taken. However, the investigation was not always sufficiently comprehensive to ensure action taken would minimise the risk of future reoccurrence. For example we found laboratory test results had been incorrectly matched to a patient of the same name. There was evidence to show staff had been spoken to about this but there was no evidence to suggest there was any review of the systems in place to try and prevent reoccurrence of this issue.

National patient safety alerts were disseminated by the senior receptionist to relevant practice staff and stored on the computer for staff to access. They told that safety alerts relating to medicines were reviewed by the Clinical Commissioning Group (CCG) pharmacist who visited the practice weekly and we saw evidence of changes made to patients' medicines as a result of these. The practice did not formally record what actions, if any had been taken in response to safety alerts so there was no clear audit trail to demonstrate they had always taken the appropriate action in response to alerts.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable adults, children and young people. We looked at training records which showed that staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, document safeguarding concerns and contact the relevant agencies. Contact details were easily accessible and displayed throughout the practice including in the patient waiting area.

The practice had a named GP leads for safeguarding vulnerable adults and children. We saw that one of the GPs had been trained to a level 3 safeguarding (the required level for GPs) to fulfil this role. The provider was unable, when requested to provide evidence to demonstrate that the second GP had received safeguarding training as required. Staff we spoke with were aware who the leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system in place to highlight vulnerable patients on the practice's electronic records. Staff had access to the required codes for recording vulnerable patients so that they could be easily identified on the patient record system. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy in place. Notices were visible in the waiting room and in consulting rooms to ensure patients were aware that they could request a chaperone to be present during their consultation . A chaperone is a person who acts as a safeguard and witness for a patient

and health care professional during a medical examination or procedure. Both nursing staff and reception staff undertook chaperoning duties at the practice. Staff records showed that they had undertaken on-line chaperone training. Staff spoken with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

We saw that practice held multi-disciplinary meetings to discuss the care and support of vulnerable adults. The health visitor also attended the practice once each week which provided an opportunity to discuss any concerns the practice might have. Reception staff told us that they would contact parents of children who did not attend appointments for their childhood immunisations.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Some medicines and vaccines are required to be stored at specific temperatures in refrigerators to ensure their effectiveness. Staff were aware of the need to maintain a cold chain and records were kept which showed that medicines and vaccines were kept at their required temperatures. The practice nurse who was responsible for maintaining the cold chain knew and was able to describe what action to take in the event of a potential failure in the cold chain.

The practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that the practice nurse had received appropriate training to administer vaccines.

Processes were in place to check medicines were within their expiry date and suitable for use. All of the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. No controlled medicines were stored at the practice. Controlled medicines are those that require extra checks and special storage arrangements because of their potential for misuse.

Data available showed that prescribing within the practice was similar to other practices within the CCG area, including antibiotic, anti-depressant and hypnotic prescribing levels.

There was a system in place for the management of high risk medicines (Methotrexate and Azathioprine), which included regular monitoring in line with national guidance. Appropriate action was taken based on the results . We checked a sample of anonymised patient records which confirmed that appropriate procedures were being followed.

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

Cleanliness and infection control

We observed the premises to be clean and tidy. Flooring and work surfaces were clear of clutter and intact making them easy to keep clean. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice nurse was the lead for infection control at the practice. Training records showed that they had undertaken training in infection prevention and control to enable them to undertake this role and provide advice to staff. Administrative staff had also received training in infection control. We saw evidence that infection control audits had been carried. These had identified that the practice had not needed to take any action

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves and aprons were available for staff to use. Clinical waste including sharps were appropriately segregated and disposed of. Contracts were in place for the safe removal of clinical waste.There was also a policy for needle stick injury, the procedure to follow in the event of an injury was displayed in all of the treatment rooms.

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

The practice did not have a policy in place for the management, testing and investigation of legionella (a

bacterium that can grow in contaminated water and can be potentially fatal). There was no risk assessment undertaken to identify any actions required to reduce the risk of infection from legionella to patients and staff. However staff told us that the taps were regularly ran as part of the weekly cleaning schedule to help minimise the risk of infection from the legionella.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, blood pressure measuring devices and the fridge thermometers.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to staff being employed. We were told that there had been one new member of staff in the last three years and we looked at their recruitment file. We saw that proof of identification, references, qualifications had been obtained.

Records we saw demonstrated that a clinical member of staff was registered with their appropriate professional body and the records indicated the practice had undertaken a criminal records check through the Disclosure and Barring Service (DBS) before the staff member started working. The senior receptionist told us that they did not have DBS checks or risk assessments in place for administrative staff who carried out chaperoning duties. The senior receptionist told us that a decision had recently been made to undertake DBS checks for all staff although this had not yet been carried out.

The practice had a recruitment policy in place. We saw that the policy detailed the recruitment and selection process but did not include details of checks (such as identity and good character checks) required to ensure only suitable staff were employed. During the inspection the practice manager told us that they would update their policy to make sure it was in line with legal requirements.

The practice had a separate policy for checking the qualifications and registration of professional staff such as GPs and nurses. We saw that the practice held information about staff registration with their professional bodies but this had not been kept up to date to ensure staff remained registered. A check against the professional register was undertaken during our inspection which confirmed staff were all currently registered.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. There were currently no staff vacancies. The practice was originally run by a single handed GP who in the last 18 months had taken on a GP partner and used a long term locum which helped ensure GP cover at the practice. The senior receptionist told us that when the practice was open there were two administrative staff on duty to cover reception and that they would cover any leave or sickness absence.

Monitoring safety and responding to risk

The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice did not have a systematic approach to the identification and management of risks to the practice. There was no specific risk log for recording risks to the service so that they could be assessed, rated and mitigated against. We saw that there were some risk assessments in place such as the control of substances hazardous to health (COSHH), display screen equipment (DSE) and a health and safety risk assessment but this was brief and contained little detail. The practice had recently undertaken a fire risk assessment which had identified actions that the practice needed to take to improve fire safety. The practice was currently in the process of implementing these.

The practice had processes in place for identifying and responding to changing risks to patients such as deteriorating health. The GP we spoke with told us that they undertook telephone triage to identify patients who required emergency appointments and would see urgent patients on the same day after surgery. They also told us how they accessed urgent secondary care for patients who may need it. For example the early intervention team for patients experiencing a mental health crisis.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage medical emergencies but was not fully equipped to deal with all the most common medical emergencies which may occur. Records showed that all staff had received training in basic life support. However, the practice did not have emergency equipment available such as oxygen, an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and an oximeter (for measuring oxygen levels and severity of asthma) as recommended by the UK Resuscitation Council. There were no risk assessments in place to identify the rationale for the decision not to hold this equipment or any information demonstrating how the practice would deal with potential situations in which the emergency equipment would be beneficial.

Emergency medicines were available in a secure area of the practice and staff we spoke with knew of their location. These included those for the treatment of anaphylaxis, hypoglycaemia, suspected meningitis and respiratory conditions. However, the practice did not routinely hold stocks of medicines for the treatment of cardiac arrest. No risk assessment had been undertaken to indicate why the practice did not consider this necessary and there was no protocol in place to manage situations where such medicine may be clinically beneficial. There were processes in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. When we asked members of staff, they all knew the location of emergency medicines and other equipment that might be needed such as airways and ambu bag (a device used to help patients who are not breathing).

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The practice had identified some potential risks which may affect their ability to provide a service in an emergency but not all those which were probable such as adverse weather conditions were included. The plan detailed how the risks identified could be managed to reduced the impact on service delivery. The document contained some relevant contact details for staff to refer to but not all. For example who to contact if power or water failed were not listed.

The practice recently had a fire risk assessment carried out by an external provider. This included actions required to maintain fire safety. At the time of the inspection the practice did not have a fire alarm or undertake fire drills. They told us that they were addressing the action plan and following our inspection sent confirmation that a fire alarm had since been fitted. We saw that fire extinguishers had been maintained, that staff had undergone fire training including how to use extinguishers, fire exits were clear with appropriate signage and evacuation procedures were displayed in the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The practice did not have any formal arrangements for discussing best practice guidance and recording agreed actions but staff told us they would access the NICE website and attend update sessions through their local Clinical Commissioning Group (CCG). The practice nurse showed us an example of NICE guidance they had printed out and were following when undertaking asthma reviews.

The practice ran clinics for patients with diabetes, asthma, hypertension and heart disease. These were run by the practice nurse and supported by the GPs. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support when needed. The practice nurse told us that they would discuss clinical matters including best practice guidance with the GPs when needed although no formally documented clinical meetings were held.

Information available to us on the practice's performance for antibiotic prescribing was comparable to other practices in the CCG area. Data available from the CCG also showed that the practice was in line with referral rates to secondary and other community care services for all conditions. However, accident and emergency attendances for patients at the practice were higher than average for the CCG area. The practice had not undertaken any action to explore the reasons for this.

Records we saw demonstrated that patients underwent reviews to ensure their treatment was appropriate. Systems were in place to encourage patients to attend those reviews. The practice used computerised tools to identify patients with complex needs who required multi-disciplinary care plans documented in their case notes. We were told about the process the practice used to review patients recently discharged from hospital, this required patients to be reviewed within a week by their GP according to need.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had specific roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice showed us three clinical audits that had been undertaken in the last 12 months. One of these had a fully completed audit cycle where the results had been analysed to demonstrate the impact of changes since the initial audit.

One of the audits related to the management of patients diagnosed with diabetes whose condition was not well controlled and was in response to Quality Outcomes Framework (QOF) performance data. (QOF is a national performance measurement tool focussing on patient outcomes.) The aim of this audit was to educate patients in the management of their diabetes. Initial findings from this audit appeared to show some improvement but work was still needed to further improve patient outcomes.

A second audit seen related to the appropriate management of patients with heart failure, at the time of our inspection, progress on the audit was limited to the identification of patients for review.

The practice used information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. QOF data showed the practice performance for the care of patients with hypertension, asthma, chronic obstructive pulmonary disease (COPD) were above the national and CCG averages. However, the practice was below the national and CCG averages for the management of patients with diabetes and dementia.

There was a protocol for repeat prescribing which was in line with national guidance. The GP checked all repeat prescriptions and would identify if patients needed to be seen for a review. This enabled them to maintain an oversight of patients' health needs.

Good

Are services effective?

(for example, treatment is effective)

The practice had a palliative care register and had regular multi-disciplinary meetings to discuss the care and support needs of patients at the end of life. Patients with complex health needs and those in vulnerable circumstances were also discussed at the multi-disciplinary team meetings.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records for two members of staff and saw that they had regular access to training. However, training records were not managed in a way which made it easy for senior staff to identify and monitor what training staff had received and whether they were up to date with attending the practice's mandatory courses.

The practice employed a long term locum GP on an informal arrangement. We noticed that the practice kept information such as evidence of their registration with their professional body. However, they did not maintain records of other training the locum GP had received to ensure there was evidence to show they had received training necessary for their continuous professional development. For example training in basic life support and safeguarding. We could not verify whether the locum GPs training was up to date.

The GP we spoke with was able to demonstrate they were up to date with their annual continuing professional development requirements and revalidation process. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise medicine and remain on the performers list with NHS England. The GP had undertaken additional training in obstetrics and gynaecology and was currently undertaking a course in family planning which would enable them to widen their expertise and the services provided to patients.

All of the staff at the practice had received an annual appraisal that identified their learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was supportive of training for relevant courses, for example the practice nurse told us that they were currently identifying a suitable asthma course to support their role.

The practice nurse was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties. For example, the administration of vaccines, cervical cytology and smoking cessation. The practice nurses also saw patients with long term conditions and had undertaken some training to fulfil this role. For example, training in chronic obstructive pulmonary disease (COPD), diabetes and asthma.

Senior staff confirmed there had not been any incidents necessitating action in response to poor performance.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those patients with complex needs. It received blood test results, X- ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Staff were aware of their individual responsibilities either in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required and an audit trail was maintained to demonstrate the action taken. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The GP told us that they followed up hospital communications within a week although no specific audits had been undertaken to ensure patients who required follow-up after hospital discharge were missed.

The practice held multi-disciplinary team meetings approximately every three months to discuss the needs of complex patients, for example those with end of life care needs or vulnerable patients. The practice told us they invited a range of health and care professionals such as district nurses, health visitors and palliative care nurses to these meetings. We saw copies of minutes in which the care needs of patients had been discussed and important information shared.

Information sharing

Electronic systems were in place for communicating with other providers. Staff told us that one of the GP partners

Good

Are services effective?

(for example, treatment is effective)

would use the Choose and Book system to make referrals. The Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital. However the other partner preferred to send a letter direct to the hospital when making a referral.

Staff told us that the GP would send a letter with the patient or that they would speak directly over the telephone to the provider if patients needed an emergency admission or were referred to A&E. The practice had signed up to the electronic Summary Care Record and planned to have this fully operational by March 2015. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (EMIS) to coordinate, document and manage patients' care and were satisfied that they knew how to use it. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice told us they had not undertaken any specific audits into the completeness of patient records.

Consent to care and treatment

We found that clinical staff were aware of the Mental Capacity Act (2005) and their duties in fulfilling it. This legislation governs decision making when people may not have the capacity to make decisions affecting them. The Mental Capacity Act referred to in the safeguarding file. Training records demonstrated that some staff had undertaken training on the Mental Capacity Act.

New patients registering with the practice were asked to provide details of any advance directives about potential future treatment and their wishes in respect of this. The practice also recorded details of any lasting power of attorney. This would enable the practice to act according to the patients wishes if the person lost their capacity to make decisions.

We saw examples on patient records of verbal consent being recorded for the administration of patient immunisations. Patient's we spoke with during our inspection were satisfied that their care and treatment was explained to them to enable them to make informed decisions.

Staff that we spoke with could not recall the need to use restraint, but were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The GP we spoke with told us that they attended meetings with the CCG in which local priorities were discussed. They worked alongside the CCG pharmacist to review their prescribing practices.

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. Patients in this age range were sent letters inviting them to attend but only a small number had taken up the opportunity in the last 12 months. NHS health checks were also carried out by the practice nurse who would refer any concerns to the GP. The practice nurse told us that the GP would try to see them the same day or they would book them in for an appointment if there were any concerns identified.

The practice identified patients who needed additional support. For example, the practice kept a register of patients with a learning disability and severe mental health problems. Practice records showed that nine out of 15 patients with a learning disability had received an annual physical health check since April 2014 and 13 out of 15 patients with mental health problems had received a health review in the last 12 months. Patients who had not been seen for three years and those over 75 years were also invited to attend the practice to ensure an accurate picture was held of their health needs.

The practice had identified through QOF the need to improve outcomes for diabetic patients. A multi-disciplinary team meeting had been held to discuss how they could educate patients with a diagnosis of diabetes to improve the management of their symptoms, health and wellbeing. This had led to more frequent reviews with practice staff and a specialist diabetes nurse.

The practice nurse had undertaken training in providing advice and support in relation to smoking cessation. The practice also offered chlamydia screening to patients aged16-24 years.

Good

Are services effective?

(for example, treatment is effective)

The practice's performance for cervical smear uptake was in line with other practices nationally. Patients who did not attend for their cervical smear were followed up by telephone. The practice nurse identified those patients who did not attend for reception staff to contact.

The practice offered a full range of immunisations for children, travel vaccines (excluding yellow fever) and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was in line with other practices for the CCG area, and those that did not attend were also followed up by the practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We found mixed evidence in respect of patient feedback on how they were treated by practice staff

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 national GP patient survey and an in-house patient survey of 51 patients undertaken in December 2013. The evidence from these source showed patients were generally 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 the practice was in line with other practices in the local CCG area for patients who rated the practice as good or very good. The practice was also in line with other practices in the local CCG area for its satisfaction scores on consultations with doctors and nurses with 77% of practice respondents saying the GP was good at listening to them and 78% saying the GP gave them enough time. However, the practice did not perform as well as others nationally in respect of patients recommending the practice to others.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 12 completed cards and the majority were positive about the service experienced. Patients said they were happy with the service received and said staff were friendly, helpful and caring. Patients commented staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We saw that 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 noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to maintain patient confidentiality when discussing patients' treatments so that personal information was kept private. The practice switchboard was located away from the reception desk.

There were glass partitions between reception and waiting area which helped keep patient information private. There was a notice in the waiting area informing patients to let staff know if they wished to discuss something in private. Reception staff we spoke with were able to give examples where a spare room had been provided for this purpose. This prevented patients overhearing potentially private conversations between patients and reception staff.

None of the feedback received raised any concerns in relation to discriminatory behaviour or where patients' privacy and dignity was not being respected. A notice was displayed in the patient area regarding 'zero tolerance' for abusive behaviour. The practice leaflet openly stated that it welcomed comments and feedback from all sections of the community. We saw children's toys and baby changing facilities were available and clean as well as notices to state breastfeeding was welcome at the practice. Newspapers and notices were displayed in languages other than English.

Care planning and involvement in decisions about care and treatment

We found mixed evidence in respect of patient feedback in respect of how involved patients felt in decisions about their care and treatment.

The national GP patient survey information 2014 showed the practice did not perform as well as others nationally in respect of patients' responses about their involvement in planning and making decisions about their care and treatment.

For example, data from the national patient survey showed 64% of practice respondents said the GP involved them in care decisions and 71% felt the GP was good at explaining treatment and results were both lower than the national average. Results were higher and in line with the national average for the practice nurse. However, the results from the practice's own satisfaction survey completed of 51 patients in December 2013 showed that all of the patients rated their consultation with a clinician as excellent, very good or good. The majority of patients also said they were clear on the outcome of their consultation.

Feedback received from patients as part of our inspection indicated that patients were satisfied with their involvement in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language and we saw contact details available for this. Many of the staff spoke more than one local community language. This helped ensure patients were able to access information they needed to make decisions.

Patients who had been identified as high risk of hospital admission were invited to have a personalised care plan and we saw examples of these in place.

Patient/carer support to cope emotionally with care and treatment

Notices and leaflets were displayed in the waiting room which signposted patients to a number of support groups and organisations. There was a notice in the waiting room inviting patients to notify staff if they were a carer so that they could be referred for a carer's assessment and support if they wished. This information was also requested when patients newly registered with the practice.

As a small established practice staff told us that they knew patients and families well and many had been with the practice for a number of years. Staff told us that many of the families in the area had good support in the community at times of need. For example there was a social worker attached to the local mosque. The GP we spoke with told us about the bereavement counselling support they would refer patients to if needed.

However, results from the 2014 national GP patient survey showed the practice was below the national average for patients who responded that the GP treated them with care and concern. Results for the practice nurse were higher and in line with the national average.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice engaged with the Clinical Commissioning Group (CCG) to deliver local priorities. For example we saw that the practice was involved in prescribing reviews with the CCG pharmacist and other benchmarking activity which enabled the practice to identify areas for improvement.

We found the practice had an understanding of it's local population and was responsive to those needs. For example, patients with complex health needs and those who were vulnerable had been identified. The practice met with multi-disciplinary teams and had care plans in place to support their care needs. The practice participated in the enhanced service to avoid unplanned hospital admissions and support patients in their own home through regular review and follow up after any unplanned admissions.

The practice offered a range of clinics for the review of patients with long term conditions. These included asthma, diabetes, hypertension and coronary heart disease clinics. This helped identify any changes to the persons condition and ensure treatment was appropriate. The practice also offered new patient health checks and the NHS health checks to patients registered so that the patients health and support needs could be identified and acted upon.

The practice had both a male and female GP. This enabled patients to be seen by a clinical member of staff they felt most comfortable with for their condition.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). We spoke with a member of the patient participation group who told us how the practice had introduced extended opening hours in order to improve access and had re-organised the information displayed in the waiting area to make it more accessible to patients.

Tackling inequity and promoting equality

We spoke with staff about how they supported different groups in the community. The practice held a register for vulnerable adults and these patients were discussed and reviewed as part of the multi-disciplinary team meetings. The practice told us that the majority of their patients were of British Pakistani ethnic origin and that they were able to refer elderly Asian patients to a group that provided care and support to them in their first language. The focus of this support group was on the health and wellbeing and quality of life. The practice did not have any examples of registering a person with no fixed abode or asylum seekers or had any specific arrangements in place to manage this if it occurred.

The practice had contact details for translation services but were told this was rarely needed. We were told that all of the staff at the practice were able to speak a second language which included those spoken in the local community. We saw that some staff had undertaken training in equality and diversity through e-learning so that they were aware of legislation that aims to protect people from discrimination.

The building was an adapted house and so access and movement around the premises could be difficult for patients who used a wheel chair. Staff told us that there were a small number of patients who used wheelchairs and that they were able to access the premises. There was a ramp leading to the premises and a doorbell which patients could use if they needed assistance. The practice had disabled toilet facilities. Consulting rooms were situated on the ground floor which made it easier for patients with a disability. However, we noticed that the reception desk was situated too high for patients who used a wheelchair to speak with reception staff and the door frame into the premises created a potential tripping hazard to service users.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams if the practice was not too busy. Baby changing facilities were available for the convenience of parents with young children.

Access to the service

Appointments were available from 9:30 am to 11.30 am on weekdays and 5.00pm to 6.30pm on a Monday, Tuesday, Thursday and Friday. Patients could also call for a telephone consultation which usually took place after morning and evening surgery. The practice offered extended opening hours between 6.30pm and 7.00pm on a Tuesday and Thursday to help accommodate the needs of patients with working or other commitments during the day.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice closed on a Wednesday afternoon and between 8.00am and 9.30am on weekdays and between 12.30pm and 5.00pm on Monday, Tuesday, Thursday and Friday. During these times the practice contracted with another provider who undertook call handling for the practice and passed on information to the GPs who told us they would respond when the practice re-opened. The number for this was available on the practice answerphone and in the patient leaflet.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed during the out of hours period (between 6.30pm and 8.30am). If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Information was available to patients about appointments on the practice website. This included how to arrange appointments and home visits and obtain urgent advice when needed. Practice staff told us that some appointments were held for walk in patients who were willing to wait. However, we did not see any information available to ensure all patients were aware of this. The practice told us that they did not currently offer online booking for appointments but did use text messaging to remind patients of their appointment and that they could cancel their appointment by text if no longer needed.

Staff told us that patients could request longer appointments if needed. They were also aware that some of the long term condition reviews undertaken by the nurse took longer and patients were offered longer appointments in such circumstances. Patients were able to request appointments with a named GP. Staff told us that they did not provide cover for any local care homes.

Patient feedback in respect of the appointment system was mixed. A small number of comments received from patients through our comment cards and in person indicated it could be difficult obtaining an appointment and getting through to the practice to make one. One patient thought it may have improved since the appointment of a second GP. However, the results from the latest national GP patient survey indicated that patients were not satisfied with the opening hours.

The GP told us that if patients had urgent needs they could call in and they would be seen after surgery if no appointments were available. They also told us that as a small practice they knew their patients well and that they were trying to educate them as to when urgent appointments were appropriate to improve access. Information about common ailments was listed in the practice leaflets and on the website.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system via a complaints leaflet and form. Whilst information on making a complaint was available on the practice website we did not see any information displayed in the practice informing patients about how to raise a complaint. Patients wishing to make a complaint would need to request a complaints leaflet from reception, which may prevent some patients from raising their concerns. The leaflet set out the expected timescales for managing complaints, who patients could go for help in making a complaint and details as to where the patient could escalate their complaint if they were dissatisfied with the response from the practice. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the two complaints received in the last 12 months and found these had been appropriately handled. Only one had been a formal complaint. We saw that complaints were dealt with in a timely way. We saw from the minutes of the practice meeting that lessons were learnt from complaints received and that they were appropriately acted on. For example there had been a complaint about the impact on waiting times on patients with pre-booked appointments as a result of walk in patients. Changes to processes were made so that patients with pre-booked appointments were seen as the priority.

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 did not have a clear vision for the future of the practice and there were no formally documented plans in place.

Staff we spoke with were clear that they wanted to deliver the best service possible. We saw the patient charter displayed on the practice website which set out the rights of the patient. These included the right to be registered with a named doctor, to receive emergency care and for their medical records to remain private.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the practice computers or as hard copies in the office. The policies we viewed showed that they were reviewed and kept up to date. However, it was clear from the evidence we gathered that not all policies contained the necessary detail needed to be followed in practice. For example, recruitment and staff training checks including those for locum staff and there was no legionella policy in place.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. The practice told us that they had achieved 835 out of 900 points during the previous year. We found that QOF data was regularly monitored by the senior receptionist and that action had been taken to improve outcomes in areas the practice had been performing less well. For example, the practice had signed up for the dementia enhanced service in order to improve patient outcomes through earlier diagnosis of dementia. Enhanced services are those that are above the standard general medical service contract.

The practice provided examples of clinical and internal audits undertaken at the practice to monitor the quality of service and systems in place. However, the practice did not have a systematic process in place to ensure that audits were always completed so they could not in each case demonstrate changes made had led to improvement in patient outcomes.

The practice arrangements for identifying, recording and managing risks were not robust. The practice did not maintain any formal risk log to ensure risks identified were acted on and implemented. We saw that the practice had some processes in place for managing risks however we identified risks during our inspection which the practice had not identified including the availability of equipment for use in a medical emergency and risks relating to legionella. Both situations had a potentially serious impact on patients, staff and vistors and as the risks had not been identified, action had not been taken to manage them effectively.

The practice held monthly practice meetings in which governance issues were discussed. We looked at minutes from the last three meetings and found that issues such as serious adverse events, complaints and some risks had been discussed. We noticed that the minutes from the meetings did not always clearly show what actions needed to be taken forward and which member of staff was responsible for ensuring the action was completed. For example in one meeting the practice had discussed emergency equipment but there was no evidence of a decision being made or actions to follow up at a later date. This indicated that when risks were identified, they were not assessed in a robust manner and action was not taken to manage risks to patients, staff and visitors effectively.

Leadership, openness and transparency

We saw from minutes that practice meetings were held approximately every three months and included all staff. Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at team meetings or informally with the practice manager.

The practice had a range of human resource policies and procedures in place to support staff. We spoke with a new member of staff who told us that they had been given induction training which had involved a period of

Are services well-led?

Good

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

supervision and shadowing other staff. Policies seen included bullying and harassment and equality and diversity. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through surveys, complaints received and had recently introduced the friends and family test (FFT). We saw that there was a comments and suggestions box for patients to use but staff told us that patients rarely used it. We looked at the results of practice's in-house survey and saw most patients had expressed a preference for the practice to be open late evenings or at weekends. We saw as a result of this the practice had introduced extended opening hours in the evening.

The practice had a patient participation group (PPG). Membership of the group was limited to four patients. We spoke with a member of the PPG who told us that they met approximately every three months and that the meetings were attended by the GPs and senior practice staff who were able to influence change. They told us that they felt the group was listened to and described some of the changes that had resulted from discussions held such as the information displayed in the waiting area.

Feedback from staff was obtained through attendance at staff meetings, appraisals and through informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistleblowing policy. Staff spoken with were aware of this policy and knew where to report concerns within the practice and to other organisations if necessary.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and we saw evidence from both clinical and administrative files that regular training was received relevant to the member of staffs roles and responsibilities.

The practice had undertaken reviews of significant events and shared findings with staff at the practice meetings to raise awareness with staff. However, reviews of significant events that had occurred did not always demonstrate what action should be taken to minimise the risk of reoccurrence.