Chelston Hall Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

We carried out an announced comprehensive inspection at Chelston Hall on 3 June 2015

Overall the practice is rated as good. Specifically, we found the practice to be good for providing well-led, safe, effective, caring and responsive services. It is also rated good for providing services for the six population groups.

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

- There was a track record and a culture of promptly responding to incidents, near misses and complaints and using these events to learn and change systems so that patient care could be improved.
- Staff were aware of their responsibilities in regard to consent, safeguarding and the Mental Capacity Act 2005 (MCA).
- The practice was clean and tidy and there were infection control procedures in place.
- Medicines were generally managed well within the practice and there were effective systems in place to deal with emergencies.
- The GPs and other clinical staff were knowledgeable about how the decisions they made improved clinical outcomes for patients and kept patient care plans under review.
- Data outcomes for patients were either equal to or above the average locally.
- Patients were complimentary about the staff and how their medical conditions were managed.
- Practice staff were professional and respectful when providing care and treatment.
- The practice planned its services to meet the diversity of its patients. Adjustments were made to meet the needs of the patients and there was an effective appointment system in place which enabled a good access to the service.

Summary of findings

- There were clear recruitment processes in place. There were robust induction processes in place for all staff.
- The practice had a vision and mission statement which were understood by staff.
- There was a leadership structure in place and staff felt supported by the practice manager and each other.

We identified one area of outstanding practice:

The practice employed a carer's support worker who was available by telephone five days a week and in person one day a week at the practice. Their role was to identify carers within the patient population, to offer them help and support, taking into account the physical and emotional pressures of being a carer. Providing information about practical support the carer's support worker could refer carers to the appropriate agencies for benefits advice, links to carers support groups and respite care.

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? The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.	**Good**
Are services effective? The practice is rated as good for providing effective services. Data showed patient outcomes were average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams of other health professionals.	**Good**
Are services caring? The practice is rated as good for providing caring services. Patient feedback about the practice was good. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.	**Good**
Are services responsive to people's needs? 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	**Good**

Summary of findings

secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led.

Despite the long term sickness of senior management staff morale remained high. Staff supported each other and felt supported by the practice manager.

The practice had a vision and strategy and staff were clear about their responsibilities in relation to this.

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.

Staff had received informal support and performance reviews Staff 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 providing services to older patients.

The practice had a high proportion of patients in this population group. The practice had responded positively to legislation which requested that patients aged 75 years or over were to be allocated a named GP. From April 2014 the practice communicated the information via its website and brochure and also written to all patients aged over 75 informing them of their named GP.

Patients aged over 75 have the choice of an appointment with any of the practice GP's or had the choice of changing their named GP should they wish to do so.

Through close liaison with the local clinical commissioning group (CCG), the practice had identified a focused group of local residential care homes to work with. This allowed a greater understanding of patient needs, improved communication links and training support from the practice to care staff at these homes.

The practice continually identified and monitored older, frail or vulnerable patients and coordinated the multi-disciplinary team (MDT) for the planning and delivery of palliative care. To aid the practice with identification of this group of patients the practice used nationally recognised predictive risk models which ensured proactive care.

The practice worked to help patients remain at home and avoid unnecessary unplanned hospital admissions through regular liaison with other health care professionals in the community. This included regular meetings, good communication and the use of special messages to out of hour's providers.

The practice employed a carer's support worker who was available by telephone five days a week and one day a week at the practice. Their role was to identify carers within the practice population, offer them help and support, and understanding the physical and emotional pressures of being a carer. The care support worker provided information about practical support and could refer carers to the appropriate agencies for benefits advice, links to local Carers Support groups and respite care.

GPs had direct access to a consultant geriatrician for advice and treatment with the aim of keeping the patient in their home or community placement according to patient need.

Summary of findings

The practice website included links to information about the promotion of health for conditions which affect older and potentially frail people.

People with long term conditions

Good

The practice is rated as good for providing services to patients with long term conditions.

The practice identified patients who were vulnerable, had chronic disease management requirements or long term needs. The practice offered an annual review for all such patients created for each person's needs rather than using a disease clinic approach. The practice had links to relevant outside agencies should the need arise including mental health teams and community provider services.

Patients with any combination or single long term condition were invited for an annual review. Attending the annual review appointment conditions specific metrics were recorded, advice and changes to management plans discussed. The practice had attracted positive feedback on their annual review clinic programme with recognition nationally from the Department of Health, national media and GP press. Within the last 12 months 97% of patients had attended their appointment, which was timed to coincide with their month of birth.

Nurses attended educational updates to ensure their skills are up to date for supporting patients in this population group. The practice involved healthcare specialists for advice where appropriate, such as diabetic and respiratory condition (Chronic Obstructive Pulmonary Disease - COPD) specialists. The practice proactively utilised community resources such as the COPD specialist nurse which supported the care of patents with long term conditions.

The practice offered annual chronic disease reviews to all patients including housebound, nursing and residential home patients. Housebound patients received a visit from the community nursing team and a practice GP visited the patient based on the outcome.

The practice signposted patients to services including physiotherapy and depression and anxiety which allowed patients to self-refer. The practice had produced and displayed an 'Easy access to your services' information leaflet which was available at reception or on the website.

The practice worked with a local care home for patients with severe learning disabilities, offering a monthly ward round by a practice GP, alongside normal patient care.

Families, children and young people

The practice is rated as good for providing services to families, children and young people.

Good

The practice provided a room and facilities for the local health visiting team to be housed within the practice. This facilitated good communication between the practice and the health visitors and enabled a deep understanding of the practice profile and population. Chelston Hall patients could access the health visitor's resident there five days a week.

The practice conducted weekly baby and childhood immunisation programs together with weekly checks for both mother and child. In addition health visitors held drop in clinics in the purpose built mother and baby suite. Health visitor and midwife teams had full access to relevant patient records.

Systems were in place to alert health visitors when children had not attended routine appointments and the practice also advised health visitors of any new children aged under five who were registered at the practice.

In 2014 the practice held a flu vaccination party at a large local venue for all children aged under five years. Due to the success of the event the practice planned to offer the same service in 2015. The event offered flu vaccinations as part of a fun day including face painting and a bouncy castle.

The practice provided written evidence of monthly safeguarding meetings. These included discussion of vulnerable children and families, especially those subject to child protection plans, children in need and vulnerable mothers to be. Meetings were attended by a GP, midwives and health visitors. Management staff told us that the format of the practice child safeguarding meetings was being replicated locally by other practices.

Ante-natal care was provided by a team of community midwives who also attended safeguarding meetings and ensured GP's were informed of any potential issues. Midwives were an integral part of the team and joined the GPs and staff for lunch which provided networking opportunities.

Women had access to a full range of contraception services and sexual health screening.

There were private areas in the practice made available for women to use when breastfeeding. Signage to advertise this service was displayed at the practice.

Summary of findings

Working age people (including those recently retired and students)

The practice is rated as good for providing services to patients of working age and those recently retired.

Good

Patients were able to book up to six weeks in advance with a mixture of face to face or telephone consultations. The practice offered pre-bookable Saturday morning appointments which were intended for patients in this population group.

The practice offered a range of services including travel advice, sexual health with access to other important services such as mental health or drug and alcohol community services.

Patients who were of working age or who recently retired were pleased with the care and treatment they received according to the results from the last three months analysis of the practice Friends and Family test. Previous patient surveys showed an equally positive response to the service offered.

The practice was proactive in offering patients NHS health checks which focused on well patients aged between 40-74 years.

The practice offered an electronic prescribing service which was recognised as a benefit to patients with busy working lives. 80% of the patient population received their prescription this way, which was an above average achievement.

Patients could drop in, email or use the new online service to request prescriptions.

The practice had recently introduced a GP Surgery pod. This was in a private room with facilities which allowed patients to monitor their own height, weight, body mass index (BMI) and blood pressure. The results were recorded on a computer system. Any results that were outside the normal range, for example, high blood pressure readings, triggered a response by the practice nurses. This also offered patients the opportunity of immediate appointments without the need to book for the measuring of BMI, medicine checks and several chronic diseases. This new service was aimed at patients in this population group.

People whose circumstances may make them vulnerable

The practice is rated as good for providing services to patients whose circumstances may make them vulnerable.

Good

Practice GPs meet on a weekly basis to review any patient that they had concerns over. Any concerns that needed to be raised with the wider team were discussed at one of the monthly multi-disciplinary team meetings.

Summary of findings

All patients with learning disabilities or vulnerable patients with chronic disease had been invited in for an annual review in their month of birth.

The practice had access to services for patients suffering from mental health and addiction problems and in terms of medication, GPs were very aware of the potential risks of prescribing medication of an addictive nature. One of the practice GPs had a lead role specialising in drug and alcohol addiction. Staff knew who this lead GP was in order to obtain guidance. The lead GP worked closely with a local drug and alcohol treatment centre.

The practice had recorded evidence which demonstrated that a high proportion of its local population may be vulnerable. Practice multi-disciplinary team meetings and safeguarding meetings were tailored towards vulnerable patients with communication between clinicians and other service providers supporting the effective delivery of services.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for providing services to patients experiencing poor mental health, including people with dementia.

Clinical staff identified patients with depression, mental health and dementia. The practice invited patients with these conditions for an annual review and patients that raised concerns with clinicians were discussed at multi-disciplinary team meetings.

Patients could be referred or could self-refer themselves to the local anxiety and depression service. For patients with a mental health problem the practice referred to community services provided by the Devon Partnership Trust. Similar services were available for patients with dementia and memory loss.

The practice worked closely with the local dementia group and received regular updates and training from the Alzheimer's Society. Many staff had become dementia befrienders.

The practice used nationally recognised examination tools used for people who displayed signs of dementia or memory loss.

Summary of findings

What people who use the service say

We spoke with four patients during our inspection. There was no patient participation group (PPG). The practice was undertaking steps to create a PPG. This included advertisements on the website and on visual display units in waiting areas. The practice manager planned to attend a course on the creation of PPGs.

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected 47 comment cards, all of which contained positive comments.

Comment cards were detailed and stated that patients appreciated the helpful staff, caring and respectful service provided, the clean and tidy building and praised the GPs, reception staff and nurses. Patients referred to being happy, very happy, delighted and grateful for the attention and care.

These findings were reflected during our conversations with the four patients we spoke with and from looking at the practice's friends and family test results from March to May 2015 and from the practice patient survey from 2014 - 2015. The feedback from patients was consistently good. Patients told us about their experiences of care and praised the level of individual care and support they received at the practice. Many patients said the service was first class.

Of the 20 friends and family test results we saw all 20 patients said they were extremely likely or likely to recommend the practice. None said they would be extremely unlikely to recommend the practice. There were many positive comments to support the findings.

Patients were happy with the appointment system. The practice offered a mixture of telephone appointments and face to face, dependent on patient need. We were told patients could make an appointment on the day and be seen following discussion with the GP. Parents said they could always make a same day appointment for their children. We were told that no patient would be turned away. On the day of our inspection we observed a patient walk in requesting to be seen the same day. The practice was able to book them in within an hour.

Patients knew how to contact services out of hours and said information at the practice was good. Patients knew how to make a complaint. None of the patients we spoke with had done so but all agreed that they felt any problems would be managed well. Patients said they felt listened to and felt confident the practice would listen and act on complaints.

Patients were satisfied with the facilities at the practice and commented on the building always being clean and tidy. Patients told us staff respected their privacy, dignity and used gloves and aprons where needed and washed their hands before treatment was provided.

Patients said they found it easy to get repeat prescriptions processed.

Areas for improvement

Outstanding practice

We identified an area of outstanding practice:

The practice employed a carer's support worker who was available by telephone five days a week and in person one day a week at the practice. Their role was to identify carers within the patient population, to offer them help and support, taking into account the physical and emotional pressures of being a carer. Providing information about practical support the carer's support worker could refer carers to the appropriate agencies for benefits advice, links to carers support groups and respite care.

Chelston Hall Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor.

Background to Chelston Hall Surgery

At the time of our inspection there were 6,925 patients registered at the service with a team of five GP partners. There was one trainee GP at the practice for six months. Three of all GPs were male and three were female. GP partners held managerial and financial responsibility for running the business. There were six nurses, two health care assistants and two phlebotomists at the practice. In addition there was a practice manager, a deputy practice manager and additional administrative and reception staff.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

Chelston Hall is open between Monday and Friday: 8.30am – 6pm. The practice is open alternate Saturday mornings between 8am – 1pm for GP appointments.

Outside of these hours a service is provided by another health care provider by patients dialling the national 111 service.

Routine appointments are available daily and are bookable up to three months in advance. Urgent appointments are made available on the day and telephone consultations also take place.

Regulated activities are provided from Chelston Hall Surgery, Old Mill Road, Torquay, Devon TQ2 6HW. During our inspection we visited this location.

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.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

Detailed findings

- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before conducting our announced inspection of Chelston Hall, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, and the local NEW Devon Clinical Commissioning Group.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

We carried out our announced visit on 3 June 2015. We spoke with four patients, four GPs, two nurses, two HCAs and members of the management, reception and administration team. We collected 47 patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients.

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

Good

Are services safe?

Our findings

Safe Track Record

The practice had a system in place for reporting, recording and monitoring significant events.

The practice kept records of significant events that had occurred and these were made available to us. Recent examples included a patient with learning disabilities seen on annual check. The patient had not understood what was required of them for self-examination. A further appointment was arranged. The GP was able to make a successful diagnosis of a serious condition. This was achieved using easy to read communication tools. The patient received surgery in hospital within 15 days of this appointment.

Another example included a patient who attended for a routine screening test. The test was inappropriate because of the patient's medical history. There was evidence that appropriate learning had taken place where necessary and that the findings were communicated to relevant staff.

Staff were aware of the significant event reporting process and how they would verbally escalate concerns within the practice. All staff we spoke with felt very able to raise any concern however small. Staff knew that following a significant event, the GPs undertook an analysis to establish the details of the incident and the full circumstances surrounding it. Significant events were discussed every six months at dedicated meetings. They were also discussed at clinical training Friday education (FRED) monthly meetings. These were well structured, well attended and not hierarchical.

There were systems in place to make sure any medicines alerts or recalls were actioned by staff.The practice manager had software in place to ensure every member of staff's desktop received a pop up alert on any relevant information. The practice manager or their deputy monitored these and filtered them appropriately to relevant members of staff. We saw examples of these from 6, 12 and 27 May which showed the system worked well.

Learning and improvement from safety incidents

The process following a significant event or complaint was both informal and formalised. GPs discussed incidents daily and also monthly at clinical meetings. GPs, nurses and practice staff were able to explain the learning from these events

Staff used incident forms at the practice and sent completed forms to the practice manager. The practice manager showed us the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result.

One of the examples of learning and improvement at the practice involved the tracking of blood tests. In the past there was no way of tracking the current status or location of a patient's blood sample. The practice had instigated a new system using modern technology, which tracks blood samples on a computer system from the time the sample is taken until the time the result arrives back at the practice. The practice was the first in the country to adopt this system.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. For example following significant events.

Reliable safety systems and processes including safeguarding

Patients told us they felt safe at the practice and staff knew how to raise any concerns. A named GP had a lead role for safeguarding older patients, young patients and children.

They had been trained to the appropriate advanced level. There were appropriate policies in place to direct staff on when and how to make a safeguarding referral. The policies included information on external agency contacts, for example the local authority safeguarding team. These details were displayed where staff could easily find them.

Safeguarding training had been completed for all staff within the last 12 months. Future safeguarding training was planned for 19 June 2015 at Chelston Hall. An external training professional was going to visit the practice to deliver face to face level three training. Attendees included all of the GPs at the practice and GPs from neighbouring practices.

There were weekly multidisciplinary team meetings with relevant attached health professionals including social workers, district nurses, palliative care, where vulnerable patients or those with more complex health care needs were discussed and reviewed. Health care professionals were aware they could raise safeguarding concerns about vulnerable adults at these meetings.

Good

Are services safe?

A safeguarding meeting took place on the day of our inspection and we accepted an invitation to observe this. The meeting was well organised with a clear agenda and written minutes were taken. Appropriate multi-disciplinary decisions were made and recorded.

Practice staff said communication between health visitors and the practice was good and any concerns were followed up. The local health visitor team was based at the practice. They carried out a weekly clinic at the practice. The practice had enabled them to customize the room provided to make it welcoming and child friendly.

The computer based patient record system allowed safeguarding information to be alerted to staff in a discreet way. When a vulnerable adult or 'at risk' child had been seen by different health professionals, staff were aware of their circumstances. Staff had received safeguarding training –and were aware of who the safeguarding leads were. Staff also demonstrated knowledge of how to make a patient referral or escalate a safeguarding concern internally using the whistleblowing policy or safeguarding policy. Both of these had been reviewed within the last 12 months.

We discussed the use of chaperones to accompany patients when consultation, examination or treatment was carried out. A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a medical examination or treatment. Patients were aware they were entitled to have a chaperone present for any consultation, examination or procedure where they feel one is required. Nurses at the practice carried out this role.

The practice had a written policy and guidance for providing a chaperone dated September 2014 policy reviewed in May 2015 for patients which included expectations of how staff were to provide assistance. Chaperone trained staff understood their role was to reassure and observe that interactions between patients and GPs were appropriate and record any issues in the patient records. The option of requesting a chaperone was advertised to patients via visual display units in patient waiting areas and on signs in consultation rooms.

Medicines Management

The GPs were responsible for prescribing medicines at the practice. There were two nurse prescribers employed. Both had obtained a relevant qualification in this at Plymouth University. Both had completed annual updates on this in March 2015.

The control of repeat prescriptions was managed well. Patients were not issued any medicines until the prescription had been authorised by a GP. Patients were satisfied with the repeat prescription processes. They were notified of health checks needed before medicines were issued. Patients explained they could use the box in the practice, send an e-mail, or use the on-line request facility for repeat prescriptions. The practice was amongst the lowest prescribers in the clinical commissioning group, which meant they did not prescribe unnecessarily.

Other medicines stored on site were also managed well. There were effective systems in place for obtaining, using, safekeeping, storing and supplying medicines. Clear checks and temperature records were kept to strengthen the audit of medicines issued and improve medicine management. Daily temperature checks were carried out and recorded on each fridge.

All of the medicines we saw were in date. Storage areas were clean and well ordered. Deliveries of refrigerated medicines were immediately checked and placed in the refrigerator. This meant the cold chain and effective storage was well maintained. We looked at the storage facilities for refrigerated medicines and immunisations, the refrigerator plug was not easily accessible therefore was very unlikely to be switched off. Signs were displayed next to the fridge instructing staff not to switch it off.

Patients were informed of the reason for any medicines prescribed and the dosage. Where appropriate patients were warned of any side effects, for example, the likelihood of drowsiness. All patients said they were provided with information leaflets supplied with the medicine to check for side effects.

The computer system highlighted high risk medicines, and those requiring more detailed monitoring. We discussed the way patients' records were updated following a hospital discharge and saw that systems were in place to make sure any changes that were made to patient's medicines were authorised by the prescriber.

Good

Are services safe?

Cleanliness & Infection Control

We left comment cards at the practice for patients to tell us about the care and treatment they receive. We received 47 completed cards. Of these, specifically commented on the building being clean, tidy and hygienic. Patients told us staff used gloves and aprons and washed their hands.

The practice had policies and procedures on infection control and these had been reviewed within the last 12 months. We spoke with the infection control lead nurse. An infection control audit had been carried out in December 2013 and repeated in March 2015. The infection control lead from the local NHS trust had attended the practice in person and walked around to assist the practice nurse infection control lead. Actions taken included replacing the curtains with disposable curtains, fabric covered stools had been replaced with plastic covered stools to enable them to be cleaned effectively.

Staff had access to supplies of protective equipment such as gloves and aprons, disposable bed roll and surface wipes. The nursing team were aware of the steps they took to reduce risks of cross infection and had received updated training in infection control. There was an annual infection control conference where a presenter from the local NHS trust delivered the latest updates to nursing staff. The lead infection control nurse had attended this.

Treatment rooms, public waiting areas, toilets and treatment rooms were visibly clean. There was a cleaning schedule carried out and monitored. There was the same template for each room which listed items such as couches, work surfaces, lights, spirometers and other equipment. Children's toys were cleaned once used and put away in nurses or GPs rooms. There were hand washing posters on display to show effective hand washing techniques.

Clinical waste and sharps were being disposed of in safely. There were sharps bins and clinical waste bins in the treatment rooms. The practice had yellow plastic bins for sharps and purple bins for cytotoxic and cytostatic (hormonal) waste. The practice had a contract with an approved contractor for disposal of waste. Clinical waste was stored securely in a dedicated secure area whilst awaiting its collection from a registered waste disposal company.

Legionella checks had been carried out every six months. The most recent one was March 2015 identified an issue. A thermostatic mixer valve required replacement. This had been successfully replaced within days. Health and safety items were a standing agenda item for the monthly clinical meetings.

Equipment

Emergency equipment available to the practice was within the expiry dates. There was an emergency bag on the second floor, one on the first floor and one on the ground floor. Each with identical equipment. Each had a cable tie on them which was replaced once they had been used and their contents replenished. The contents of each was recorded in writing. The practice had a system using checklists to monitor the dates of emergency medicines and equipment so they were discarded and replaced as required.

Equipment such as the weighing scales, blood pressure monitors and other medical equipment were serviced and calibrated where required. There was a contract in place with a healthcare contractor to maintain and service the equipment on a six monthly basis.

The practice had modern equipment including ECG and spirometry equipment, which was maintained and calibrated by local providers such as Torbay Hospital. The practice had a Doppler device which was used to assess patients' venous blood supply, for example leg ulcers.

Portable appliance testing (PAT) where electrical appliances were routinely checked for safety was last carried out by an external contractor in November 2014.

Staff told us they had sufficient equipment at the practice.

Staffing & Recruitment

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well. The practice had six nurses, two health care assistants and three phlebotomists. There were five GPs, all of whom were partners. All five GPs were part time. All of the nursing staff had worked here for over five years apart from one new joiner. The GPs had all worked here for many years.

The practice had a low turnover of staff. GPs told us they also covered for each other during shorter staff absences.

The practice used a team approach where the workload for part time staff was shared equally. Each team had

appointed clerical support. Staff explained this worked well but there remained a general team work approach where all staff helped one another when one particular member of staff was busy.

Recruitment procedures were safe and staff employed at the practice had undergone the appropriate checks prior to commencing employment. Clinical competence was assessed at interview. Once in post staff completed an induction which consisted of ensuring staff met competencies and were aware of emergency procedures.

Criminal record checks via Disclosure Barring Service (DBS), were performed for all clinical staff including GPs, nursing staff, health care assistants and any staff who had direct access with patients. Recorded risk assessments had been performed explaining why some clerical and administrative staff had not had a criminal records check.

The practice had disciplinary procedures to follow should the need arise.

Each registered nurse Nursing and Midwifery Council (NMC) status was completed and checked annually to ensure they were on the professional register to enable them to practice as a registered nurse.

Monitoring Safety & Responding to Risk

The practice had a suitable business continuity plan that documented the practice's response to any prolonged events that may compromise patient safety. For example, this included computer loss and lists of essential equipment. This was last updated December 2014.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at clinical meetings and at practice meetings if relevant to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

There was a system in operation to ensure one of the nominated GPs covered for their colleagues when necessary, for example home visits, telephone consultations and checking blood test results.

Arrangements to deal with emergencies and major incidents

Appropriate equipment was available and maintained to deal with emergencies, including if a patient collapsed. Administration staff appreciated that they had also been included on the basic life support training sessions. All clinical staff received emergency first aid training annually. All administration staff received this training every three years. This had last been completed in December 2014 for clinical staff and in March 2015 for all administration staff.

Fire training had also been completed for all staff in March 2015. The practice completed an annual evacuation drill. There was a system in place to allow staff to alert others if they were in danger of violence or aggression. Devon Fire Service had visited the site to complete a fire audit in October 2014 and found the practice to have achieved a reasonable standard of safety. Actions undertaken as a result included removing pots of paint from the plant room. A fire audit was completed every year.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

There were examples where care and treatment followed national best practice and guidelines. For example, emergency medicines and equipment held within the practice followed the guidance produced by the Resuscitation Council (UK). The practice followed the National Institute for Health and Care Excellence (NICE) guidance and had formal meetings to discuss latest guidance. Where required, guidance from the Mental Capacity Act 2005 had been followed. Guidance from national travel vaccine websites had been followed by practice nurses.

Every week there was a nurses meeting at the practice held with Chelston Hall, Shiphay Manor and Abbey Road practices. Latest updates were discussed. Recent examples included presentations on heart disease and medicines.

The practice had opted out of using the quality and outcome framework (QOF) to measure their performance in January 2014 until March 2014. The practice re-entered QOF from April 2014 onwards. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries.

The QOF data for this practice showed they generally achieved higher than national average scores in areas that reflected the effectiveness of care provided. The local clinical commissioning group (CCG) data demonstrated that the practice performed well in comparison to other practices within the CCG area.

The practice was able to demonstrate that QOF had been used to identify any areas which needed improvement. For example, when the practice fell short of the target in managing blood pressures for chronic kidney disease patients, actions had been put in place to address this in the future. This included regular blood pressure checks now being undertaken for these patients and staff were now updating these records on a more frequent basis.

The practice had over achieved their target in management of patients with heart problems, stroke issues, asthma, cancer and palliative care.

Management, monitoring and improving outcomes for people

The practice told us they were keen to ensure that staff had the skills to meet patient needs and so nurses had received training including baby immunisations, respiratory issues, diabetes care, cervical screening and travel vaccinations.

The practice employed a care support worker. GPs referred patients her as she carried out home visits, conducted home assessments, checked what equipment carers needed, benefits assessments, access to grants for house alterations. This enabled patients to remain at home avoiding hospital admissions where appropriate. Carer's annual health checks were carried out by the practice.

GPs in the practice undertook minor surgical procedures and joint injections in line with their registration and NICE guidance. For example, a GP at the practice was trained to carry out vasectomies at the practice, in partnership with Devon Doctors. The staff were appropriately trained and kept up to date. There was evidence of regular clinical audit in this area which was used by GPs for revalidation and personal learning purposes.

CQC data identified three areas for follow up. These included the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less. The practice was now managing blood pressure much more closely and record results immediately on the system.

The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months. The practice had now identified 65 patients with dementia and plans were in place to provide them with face to face reviews before the end of March 2016.

There were 59 patients with mental health issues recorded. Face to face reviews had been undertaken for each of these patients within the last 12 months.

The practice had created a template for face to face reviews of patients with all types of conditions which had been adopted by other practices across the CCG and was considered notable practice.

The clinical auditing system used by the GPs assisted in driving improvement. All GPs were able to share examples of audits they had performed. Clinical audits included splenectomy audits, optimising prescribing audits and

medicines audit. A pregabalin medicine audit carried out in October 2014 and again in March 2015. 13 patients had been audited. There had been identified action points for 8 patients. Action points included reviewing the number of patients on the medicine and their dosage rates according to individual need.

An asthma medication audit carried out in November 2014 identified that an asthma action plan had not always been provided to every patient. This had been acted upon. A new audit was planned. Not all audits had followed a complete audit cycle. For example, the deadline for completion of a second audit of asthma management had passed in March 2015. This was therefore overdue for completion. GPs stated they planned to complete this by the end of June 2015.

Effective Staffing

All of the GPs in the practice participated in the appraisal system leading to revalidation of their practice over a five-year cycle. The GPs we spoke with told us and demonstrated that these appraisals had been appropriately completed. One of the GP partners was a vice dean at the Peninsular Medical School deanery and kept staff up to date with the latest training developments.

The practice was a training practice for new GPs. Two of the GPs were qualified GP trainers. One of the nurses was a qualified nurse trainer. The practice released this nurse one day a week in order to undertake nurse management for the CCG. This nurse was also the lead for Torbay Nurses a networking training group. Another nurse was a qualified mentor.

Nursing staff had received an annual formal appraisal and kept up to date with their continuous professional development programme, documented evidence confirmed this. A process was also in place which showed clerical and administration staff received regular formal appraisal.

There was a comprehensive induction process for new staff which was adapted for each staff role. A newly recruited nurse had re-joined the practice. This member of staff had received a six weekly placement at the end of their training. They were currently undertaking the practice nurse foundation programme. This included ear care, respiratory diseases, immunisations and coronary heart disease. They were assigned a practice nurse trainer on a 1:1 basis to work with them. Every Thursday they met up with the lead nurse to discuss any learning points. They also met up with a GP every Thursday for the same reason. The nurse had chosen to specialise in baby immunisations and this was supported by the practice.

The staff training programme was monitored to make sure staff were up to date with training the practice had decided was mandatory. This included basic life support, safeguarding, fire safety and infection control. Staff said that they could ask to attend any relevant external training to further their development. Staff told us they had completed this in December 2014 and it was repeated annually. If staff missed this session there were mop up sessions available around the Bay for staff to attend.

There was a set of policies and procedures for staff to use and additional guidance or policies located on the computer system.

Working with colleagues and other services

The practice worked effectively with other services. Examples given were excellent liaison with health visitors who the practice allowed to be based at their premises in a health visitor suite. For any child concerns, there was immediate access to health visitors for advice and action.

We spoke with external health professionals who spoke highly of the close liaison with the practice.

There was a weekly midwifery clinic which the practice organised on their premise which was advertised to patients. The midwife introduced new parents to the health visitors at the practice to ensure a joined up approach and continuity of care. The GPs liaised with counsellors for depression and anxiety who saw patients at the practice. A GP also worked at a local drug and alcohol dependency unit. This GP was a fully trained drug and alcohol worker and had regular liaison with this service.

Once a week there was a multidisciplinary team meeting to discuss vulnerable patients, high risk patients and patients receiving end of life care. This included the multidisciplinary team such as, health visitors, district nurses, community matrons, social workers and the mental health team.

Information Sharing

The practice worked effectively with other services. For example, the practice advised support agencies of any concerns regarding older patients providing them with relevant information. Communication at multi-disciplinary

Good

Are services effective?

(for example, treatment is effective)

team meetings linked closely with the practice carer's support worker. This ensured that the most appropriate professional made contact with the patient. Support agencies that the practice worked with included local mental health services, drug and alcohol support services and the Torbay and Southern Devon Health and Care Trust community services.

The communication process with the out of hours service GPs meant that they were able to access patient records (with patient consent) using a local computer system. The practice GPs were informed when patients were discharged from hospital. This prompted a medication review.

Consent to care and treatment

All consultations are carried out with patients (and their families/carers if appropriate), by qualified personnel in the privacy of the consultation room. Records of all consultations and treatments are kept electronically within the patients notes.

All patients wishing to register with Chelston Hall Surgery had been asked to complete a new patient questionnaire which informed the practice of past health and present lifestyle. This enabled the practice to meet a patient's medical needs until medical notes arrived from the previous practice.

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. Formal training in the Mental Capacity Act 2005 had been undertaken by GPs, nurses and senior administrative staff. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice.

For example, we saw evidence of a GP being involved in a Best Interests meeting with a patient who lacked the capacity. GPs demonstrated an understanding of both Gillick and Fraser guidelines (used to decide whether a child or young person 16 years and younger is able to consent to their own medical treatment without the need for parental permission or knowledge). Patients with a learning disability and those with dementia were supported to make treatment decisions through the use of care plans, which they were involved in agreeing.

Health Promotion and Prevention

The practice promoted independence and encouraged self-care via lifestyle interventions. There was a weight management referral service for patients and refers to dieticians should it be necessary. The practice had a private room with facilities for patients to measure their own height, weight, body mass index (BMI) and blood pressure. Patients told us they found this facility useful.

There were regular appointments offered to patients with complex illnesses and diseases. The practice manager explained that this was so that patients could access care at a time convenient to them. A full range of screening tests were offered for diseases such as prostate cancer, cervical cancer and ovarian cancer. Vaccination clinics were organised on a regular basis which were monitored to ensure those that needed vaccinations were offered.

Patients were encouraged to adopt healthy lifestyles and were supported by services such as a walking group, "FIT Bay" which organised walks around Torbay, cycling and gym referrals.

NHS Health checks for patients aged 40 years plus were offered and referrals had been made to support these patients. Smoking cessation advice was available to patients and their smoking status was recorded. Patients with diabetes received advice where staff discussed how changes to lifestyle, diet and weight could influence their diabetes.

All patients with learning disability were offered a physical health check each year. Easy to read communication methods and tools were in place including pictures and diagrams.

Staff explained that when patients were seen for routine appointments, prompts appeared on the computer system to remind staff to carry out regular screening, recommend lifestyle changes, and promote health improvements which might reduce dependency on healthcare services.

The diabetic appointments supported and treated patients with diabetes which included education for patients to learn how to manage their diabetes through the use of insulin. Health education was provided on healthy diet and life style.

There was a range of leaflets and information documents available for patients within the practice and on the website. These included information on family health, travel advice, long term conditions and minor illnesses. Website links were easy to locate.

Are services effective?

(for example, treatment is effective)

Good

Family planning, contraception and sexual health screening was provided at the practice. Two GPs were trained to carry out contraceptive implants and coil fittings.

The practice offered a basic travel vaccination service.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients told us they felt well cared for at the practice. They told us they felt they were communicated with in a caring and respectful manner by all staff. Patients spoke highly of the staff and GPs. We did not receive any negative comments about the care patients received or about the staff.

We left comment cards at the practice for patients to tell us about the care and treatment they received. We collected 47 completed cards which contained very detailed positive comments. All comment cards stated that patients were grateful for the caring attitude of the staff who took time to listen effectively.

Patients were not discriminated against and told us staff had been sensitive when discussing personal issues.

We saw that patient confidentiality was respected within the practice. The waiting areas had sufficient seating and were located away from the main reception desk which reduced the opportunity for conversations between reception staff and patients to be overheard. There were additional areas available should patients want to speak confidentially away from the reception area. We heard, throughout the day, the reception staff communicating pleasantly and respectfully with patients.

Conversations between patients and clinical staff were confidential and conducted behind a closed door. Window blinds, sheets and curtains were used to ensure patient's privacy. The GP partners' consultation rooms were also fitted with dignity curtains to maintain privacy.

We discussed the use of chaperones to accompany patients when consultation, examination or treatment were carried out. A chaperone is a member of staff or person who is present with a patient during consultation, examination or treatment. Posters displayed informed patients they were able to have a chaperone should they wish.

Care planning and involvement in decisions about care and treatment

Patients told us that they were involved in their care and treatment and referred to an on-going dialogue of choices and options. Comment cards related patients' confidence in the involvement, advice and care from staff and their medical knowledge, the continuity of care, not being rushed at appointments and being pleased with the referrals and on-going care arranged by practice staff. We were given specific examples where the GPs and nurses had taken extra time and care to diagnose complex conditions.

Data from the national patient survey showed 88% of 118 practice respondents said the GP involved them in care decisions this was higher than the local (CCG) average of 81%.

GPs and nurses were able to demonstrate an understanding of Gillick guidelines used to help clinicians decide whether a child under 16 years has the legal capacity to consent to medical examination and treatment without the need for parental permission or knowledge.

Patient/carer support to cope emotionally with care and treatment

The practice employed a carer's support worker who was available by telephone five days a week and in person one day a week at the practice. Their role was to identify carers within the patient population, to offer them help and support, taking into account the physical and emotional pressures of being a carer. Providing information about practical support the carer's support worker could refer carers to the appropriate agencies for benefits advice, links to carers support groups and respite care.

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 92% of the 118 respondents from this practice in the national GP patient survey stated that they were treated with kindness and care. The patients we spoke to and the comment cards we received were consistent with this information.

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

Staff told us families who had suffered bereavement were contacted by their usual GP. GPs said the personal list they held helped with this communication. There was a counselling service available for patients to access.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us they felt the staff at the practice were responsive to their individual needs. They told us that they felt confident the practice would meet their needs. GPs told us that when home visits were needed, they were normally made by the GP who was most familiar with the patient.

Systems were in place to ensure any referrals, including urgent referrals for hospital care and routine health screening including cervical screening, were made in a timely way. Patients told us that any referral to secondary care had always been discussed with them.

An effective process was in place for managing blood and test results from investigations. When GPs were on holiday the other GPs covered for each other and results were reviewed within 24 hours, or 48 hours if test results were routine. Patients said they had not experienced delays receiving test results.

There was currently no patient participation group (PPG). The practice had attempted to create a PPG in 2011 and again in 2014 without success. The practice was attempting to organise a PPG in 2015. Advertisements about the PPG were on display on the visual display units in the waiting room and on the practice website.

The practice liaised with local pharmacies to provide medication in blister packs for patients with memory problems. The practice offered an electronic prescription service which is a benefit to older patients saving them trips to and from the practice. The practice was consistently one of the highest performers for electronic prescribing in the South West, achieving over 80%.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. Easy to read leaflets were available for patients with learning disabilities. Letters had been sent out to patients in easy to read formats where appropriate.

The number of patients with a first language other than English was low and staff said they knew these patients well and were able to communicate well with them. The practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

General access to the building was good. The practice had an open waiting area and sufficient seating. The reception and waiting area had sufficient space for wheelchair users. The majority of consulting rooms had level access. There was a lift in the building. Ground floor treatment rooms were available for patients unable to use lifts or stairs.

There was no evidence of discrimination when making care and treatment decisions.

Access to the service

Patients were able to access the service in a way that was convenient for them and said they were happy with the system. Of the 47 comment cards we received, one mentioned that they felt a receptionist's behaviour had been rude on one occasion. However, all other comments, discussions and feedback indicated that patients were happy with the professionalism of staff including receptionists and the arrangements for access.

There was a large lift available at the practice which provided access to all floors. Patients using pushchairs and wheelchairs told us they found the lift was large enough for their needs. Treatment rooms were available on the ground floor if patients did not wish to or were unable to use the lift or stairs.

The practice had instigated a text messaging service to landlines from March 2015. The practice had sent out 20 such messages to patients inviting them in for blood pressure checks. Of these 13 patients had attended. This was of benefit to patients who did not possess mobile phones. The practice population contained a significant proportion of elderly patients who fell into this category. As a result the practice had sent out a further 100 messages in June 2015 and responses were encouraging so far.

The GPs provided a personal patient list system. These lists were covered by colleagues when GPs were absent. Patients appreciated this continuity and GPs stated it helped with communication.

The GP patient national patient survey showed that 96% of the 118 practice respondents rated their experience of getting an appointment as good or very good. This was higher than the national average.

Good

Are services responsive to people's needs?

(for example, to feedback?)

These findings were reflected during our conversations. Patients were happy with the appointment system and said they could get a same day appointment if necessary.

Information about the appointment times were found on the practice website and on notices at the practice. Patients were informed about the out of hours arrangements by a poster displayed in the practice, on the website and on the telephone answering message.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The practice had received two formal complaints in the last 12 months. Other minor complaints had been dealt with immediately as they arose, for example, a complaint about the lift being out of service had been resolved within 24 hours.

Patients told us they had no complaints. Patients were aware of how to make a complaint and said they felt confident that any issues would be managed well.

The posters displayed in the waiting room and patient information leaflet explained how patients could make a complaint. The practice website also stated that the practice welcomed patient opinion by sharing ideas, suggestions, views, and concerns.

The complaints procedure stated that complaints were handled and investigated by the practice manager and would initially be responded to within three days. Records were kept of complaints which showed that patients had been offered the chance to take any complaints further, for example to the parliamentary ombudsman.

Staff were able to describe what learning had taken place following a complaint. Complaints were also discussed as a standing agenda item at the clinical meetings held every month.

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 clear aims and objectives. These stated that the purpose of Chelston Hall Surgery was the delivery of safe and effective care of patients who were ill or believed themselves to be ill, with conditions from which recovery is generally expected, for the duration of that condition, including relevant health promotion advice and referral for specialist care as appropriate, reflecting patient choice wherever practicable. It also included the management of patients who were terminally ill and management of chronic disease in the manner determined by the practice, in discussion with the patient and their relatives or carers as appropriate.

The practice's priority was to provide the highest standard of clinical care to patients registered with the practice, ensuring they worked collaboratively with other healthcare providers and support organisations, to enable more practice patients to be treated in a primary care setting, closer to home.

Staff knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff spoke positively about communication, team work and their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work. There was a stable staff group and many staff had worked at the practice for many years and were positive about the open culture.

We were told there was mutual respect shared between staff of all grades and skills and that they appreciated the non-hierarchical approach and team work at the practice.

Staff said the practice was small enough to communicate informally through day to day events and more formally though meetings and formal staff appraisal.

Governance Arrangements

The practice met up with the five partners once a month. This was called a partners meeting. The practice also held Friday education sessions (known as FRED at the practice) on the last Friday of the month. All GPs, nurses and the practice manager or deputy manager attended FRED meetings. The practice had a human resources manager and staff knew who to go to for advice or support.

Staff were familiar with the governance arrangements in place at the practice and said that systems used were both informal and formal. Issues were discussed amongst staff as they arose. GPs met daily and discussed any complex issues, workload or significant events or complaints. These were often addressed immediately and communicated through a process of face to face discussions or email. These issues were then followed up more formally at monthly clinical meetings where standing agenda items included significant events, near misses, complaints and health and safety. Staff explained these meetings were well structured, well attended and a safe place to share what had gone wrong.

The practice used the quality and outcomes framework (QOF) to assess quality of care as part of the clinical governance programme. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF scores for Chelston Hall were in the upper quartile of the CCG. In 2012-13 the practice had achieved 100% of their QOF target. In 2013-14 they had opted out of QOF.

Leadership, openness and transparency

Staff were familiar with the leadership structure, which had named members of staff in lead roles. GPs had lead roles such as safeguarding, diabetes, learning disabilities and training. There was a lead nurse for infection control.

Staff spoke about effective team working, clear roles and responsibilities and talked about a supportive non-hierarchical organisation. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff described an open culture within the practice and opportunities to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. Staff were aware of where to find these policies if required. All of the policies were on the practice intranet computer system and on paper.

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

Patients we spoke with in the waiting room had not been formally asked for their views about the practice but they were aware there were suggestion boxes in the waiting room. The website signposted patients to give feedback if they chose.

Are services well-led?

Good

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

The practice had made unsuccessful attempts to set up a PPG from 2011-2014. The practice was again attempting to create a PPG in 2014. The PPG was advertised on the practice website and on visual display units at the practice.

The practice carried out its own annual surveys. The November 2014 survey had 200 respondents and asked questions about patient satisfaction, cleanliness, staff attitudes. It was based on a system called Productive General Practice from the NHS Institute for Innovation and Improvement. Much of the feedback was about waiting times. As a result of this the practice had put in place actions such as touch screen sign in training for patients, electronic prescription service training for patients and a general improvement in signage and health promotion information displayed around the practice.

Management lead through learning & improvement

A process was followed so that learning and improvement could take place when events occurred or new information was provided. For example, the practice held monthly meetings to discuss any current topics and review any newly released national guidelines and the impact for patients. For example, unplanned admissions were discussed in October 2014; medicines management was discussed February 2015. A presentation from the British Heart Foundation had taken place in March 2015. There was formal protected time set aside for continuous professional development for staff and access to further education and training every month.

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. The practice had a suitable business continuity plan to manage the risks associated with a significant disruption to the service. This included, for example, if the electricity supply failed, IT was lost or if the telephone lines at the practice failed to work.

There were environmental risk assessments for the building. For example annual fire assessments, electrical equipment checks, control of substances hazardous to health (COSHH) assessments and visual checks of the building had been carried out.