Balderton Medical Practice

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Balderton Medical Practice on 25 February 2015. This is the first time we have inspected this practice.

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 was also rated as good for providing services for all the population groups.

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

- Comments from patients were generally very positive about the care and services they received. They said that they were treated with kindness, dignity and respect and were involved in decisions about their care and treatment.
- The practice was accessible and well equipped to meet patients' needs.
- Patients had access to care and treatment when they needed it. Patients were usually able to make an urgent appointment or request a telephone consultation the same day. The practice was working to further improve access to non-urgent appointments.
- Procedures were in place to help keep patients safe and to protect them from harm.
- Patients felt listened to and able to raise concerns about the practice. Concerns were acted on to improve the service.
- Staff felt valued and well supported. The practice had a motivated staff team with appropriate knowledge and skills to enable them to carry out their work effectively. Staff were actively supported to acquire new skills to ensure high quality care.
- Systems were in place to assess and monitor the quality and safety of services that people received; although the clinical audit programme required developing to improve outcomes for patients.
- The services were well-led. The clinical leadership had been strengthened following the appointment of three salaried GPs, one of which was the clinical lead.

Summary of findings

- The practice obtained and acted on patients views. The Patient Participation Group (PPG) worked in partnership with the practice to improve the services for patients.

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

In addition the provider should:

- Establish an on-going clinical audit programme linked to medicines information, safety alerts and significant events to improve outcomes for patients.
- Ensure that information available to patients enables them to understand the complaints process.

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. Arrangements were in place to ensure that the practice was clean, safe and adequately maintained. Systems were also in place to keep patients safe and to protect them from harm. Risks to patients were assessed and appropriately managed. The practice was open and transparent when things went wrong. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Learning took place and appropriate action was taken to minimise incidents and risks. There were enough staff to keep people safe. Systems were in place to ensure that medicines were managed safely and appropriately.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff worked closely with other providers to meet patients' needs. Patients' needs were assessed and their care and treatment was delivered in line with evidence based practice. The practice had an Alternative Personalised Medical Services (APMS) contract, which meant that only salaried GPs were employed. There had been a high turnover of GPs and use of locums in the last 12 months. Three permanent GPs had recently been appointed, which had improved the consistency of clinical practice and continuity of care for patients.

Limited clinical audits had been completed in the last twelve months, due to the high turnover of GPs. The new GP lead planned to put an on-going audit programme in place to improve outcomes for patients. The practice had a motivated staff team, with appropriate knowledge and skills to carry out their work. Staff were actively supported to acquire new skills to ensure high quality care.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients described the staff as friendly and caring, and said they were treated with dignity and respect. Patients were involved in decisions about their care and treatment, and their wishes were respected. Staff supported patients to cope emotionally with their health and conditions. We observed that patients' privacy, dignity and confidentially were maintained. Staff were caring, respectful and polite when dealing with patients.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients told us that the practice was responsive to their needs. Patients had access to care and treatment when they needed it. They were usually able to make an urgent appointment or request a telephone consultation the same day. The practice was working to further improve access to non-urgent appointments.The services were flexible and were planned and delivered in a way that met the needs of the local population. There was a culture of openness and people were encouraged to raise concerns. Patients' concerns and complaints were listened to and acted on to improve the service.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice obtained and acted on patients' views to improve the service. The practice had a clear vision to deliver high quality care and services for patients, which was shared by the staff team. Systems were in place to assess and monitor the quality and safety of services that people received. The clinical leadership and stability of staff had been strengthened, following the recent appointment of three salaried GPs, one of which was the clinical lead. Staff said that they felt valued, well supported, and involved in decisions about the practice. The culture of the organisation was open, and staff felt able to raise any issues with senior staff as they were approachable.

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. Patients over 75 years were invited to attend an annual health check, and had a named GP to ensure their needs were being met. The practice worked closely with other services to enable patients to remain at home, where possible. The practice was signed up to an enhanced service to avoid unplanned admissions into hospital, and had identified older patients who were at risk of admissions. Care plans had been developed for such patients, which were kept under review. The practice was also signed up to provide enhanced services for patients with dementia, and proactively screened patients to help facilitate early referral and diagnosis where dementia was indicated. Flu, pneumococcal and shingles immunisations were actively offered to patients. Home visits were carried out to patients unable to attend the practice. Carers were identified and supported to care for older people.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Patients were offered an annual health review including a review of their medicines.They also had a named GP to ensure their needs were being met. When needed, longer appointments and home visits were available. Patients' with long term conditions and other needs were reviewed at a single appointment where possible, rather than having to attend various reviews. Patients were educated and supported to self-manage their conditions. The practice kept a register of patients with complex needs requiring additional support, and worked with relevant professionals to meet their need. Care plans had been developed for such patients, which were kept under review. Carers were identified and supported to care for people with complex long-term conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Priority was given to appointment requests for babies and young children. Systems were in place for identifying and following-up children at risk of abuse, or living in disadvantaged circumstances. The practice worked in partnership with midwives, health visitors and school nurses to meet patients' needs. Immunisation rates were high for all standard childhood immunisations. Children were able to attend appointments outside

Summary of findings

of school hours. The practice provided maternity care and family planning services. The practice also provided advice on sexual health for teenagers, and screening for sexually transmitted infections.

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). Patients were offered telephone consultations and were able to book non-urgent appointments around their working day by telephone or on line. The practice offered a 'choose and book' service for patients referred to secondary services. This provided greater flexibility over when and where their test took place, and enabled patients to book their own appointments. NHS health checks were offered to patients aged 40 to 74 years, which included essential health checks and screening for certain conditions. The practice also offered health promotion and screening appropriate to the needs of this age group.

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 areas available to patients offered disabled access and a loop hearing system.

For patients who were registered blind or deaf, an alert was in place on the computer system to alert staff to their needs and support they may require. The practice held a register of patients living in vulnerable circumstances including people with learning disabilities. Patients were offered extended or same day appointments or telephone consultations. They were also invited to attend an annual health review, and had an allocated GP to ensure their needs were being met. The practice worked with relevant services to ensure vulnerable people received appropriate care and support. When needed, longer appointments and home visits were available. Carers were identified and offered support, including signposting them to external agencies.

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). The practice held a register of patients experiencing poor mental health. Patients were offered extended or same day appointments or telephone consultations. When needed, longer appointments and home visits were available. Patients were invited to attend an annual health review, and had an allocated GP to ensure their needs were being met. The practice worked with mental health services to ensure that appropriate risk assessments and care plans were in place, and that

patients' needs were regularly reviewed. Patients were supported to access emergency care and treatment when experiencing a mental health crisis. The practice was signed up to provide enhanced services for patients with dementia, and proactively screened patients to help facilitate early referral and diagnosis where dementia was indicated.

Summary of findings

What people who use the service say

Prior to our inspection we left comment cards for patients to complete. We received five completed comment cards. These were mostly positive about the care and services patients received. Patients described the staff as polite, caring and helpful. Two patients said that they often saw a different GP at each appointment, which did not provide continuity of care. One person also commented on the high turnover of GPs, and difficulty in obtaining a same day appointment.

We spoke with seven patients during our inspection. All patients said they were happy with the care they received, and were treated with dignity and respect. They also felt the staff were approachable, caring, and listened to them.

Patients told us that access to appointments had improved.They said they were usually able to make an urgent appointment, or request a telephone consultation the same day. Two patients said they often had to wait two weeks to obtain a non-urgent appointment. They also said that there had been too many changes in GPs to form a relationship.

We also spoke with senior staff at two care homes where patients were registered with the practice. They were complimentary about the services, and said the practice staff were responsive to patients' needs.

The practice obtained patients' views to improve the service. The practice had an active Patient Participation Group (PPG). The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

The practice and the PPG issued an annual satisfaction survey to patients. We looked at the 2013/2014 survey results, which 57 patients completed. The results were mostly positive; 97% of patients found the staff welcoming, 94% felt listened to, 90% said they were able to get a same day appointment and 80% said they would recommend the surgery to a family or friend. Negative comments mostly related to the staff changes.

We spoke with the chairperson of the PPG. They told us the PPG had agreed the action points from the last survey, and that the practice staff worked with them to improve the service. There had been various improvements to the service over recent months.

We also reviewed the patient reviews of the practice on NHS Choices, completed in the last 12 months. Five out of nine comments were very positive about the care and treatment patients received. Negative comments mostly related to the turnover of GPs, lack of continuity of care and the conduct of certain locums.

Areas for improvement

Action the service SHOULD take to improve

- Establish an on-going clinical audit programme linked to medicines information, safety alerts and significant events to improve outcomes for patients.
- Ensure that information available to patients enables them to understand the complaints process.

Balderton Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and included a GP, a practice manager, a second inspector and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of service.

Background to Balderton Medical Practice

Balderton Medical Practice provides primary medical services to approximately 5,300 patients. The practice is based in Newark in north Nottinghamshire.

Newark is an area of lower social deprivation with good local facilities and amenities.The address where the regulated activities take place is: Balderton Primary Care Centre, Lowfield lane, Balderton, Newark NG24 3HJ.

The practice is managed by Malling Health (UK) Limited, which is an organisation that manages various health services in England.

The clinical team at the practice includes three salaried male GPs, an advanced nurse practitioner, two practice nurses and a health care assistant. The clinical team are supported by the business manager and an administrative team including reception staff.

There are three whole time equivalent GPs working at the practice, in addition there are 2.6 whole time equivalent nursing staff.

The practice holds an Alternative Personalised Medical Services (APMS) contract to deliver essential and enhanced primary care services. The contract means only salaried GPs are employed and there are no partners.

Balderton Medical Practice has opted to take part in the Prime Minister's challenge winter pilot. This has seen the practice offering same day urgent walk-in appointments on Monday and Friday mornings to help improve access to primary care and alleviate pressures for NHS services. During the evenings and at weekends an out-of-hours service is provided by Central Nottinghamshire Clinical Services (CNCS) Contact is via the NHS 111 telephone number.

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. The practice had not previously been inspected and that was why we included them. This inspection was planned to check whether the provider was 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.

Detailed findings

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
- 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)

Prior to our inspection we reviewed information about the practice and asked other organisations to share what they knew about the service. We also obtained feedback from three external professionals who worked closely with the practice, including a health visitor, MacMillian nurse and care co-ordinator.

We carried out an announced visit on 25 February 2015. During our visit we checked the premises and the practice's records. We spoke with various staff including a nurse practitioner, a practice nurse, a healthcare assistant, two GPs, reception and administrative staff, the business manager and senior managers. We also received comment cards we had left for patients to complete and spoke with patients and representatives 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 and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records and incident reports for the last two years. Senior manager changes at the practice had resulted in accident records only being available from 2013. Records showed that appropriate action was taken in response to incidents that had occurred. For example, a medicine refrigerator was showing temperatures outside of the normal range. Following the incident, improved equipment and checks were put in place to monitor the temperature.

A system was in place to ensure that staff were aware of national patient safety alerts and relevant safety issues, and where action needed to be taken. Records showed that safety incidents and concerns were appropriately dealt with. Alerts were also discussed at practice meetings to ensure all staff were aware of these, and action that needed to be taken.

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 that had occurred during the last two years and we were able to review these. Significant events were a standing item on the practice meeting agendas and we saw evidence of this on file. All significant events and complaints were reported to the provider each month, including any actions taken and lessons learnt.

The provider held a meeting every two months to complete a wide analysis of significant events and complaints across all its services. Where patterns and trends were identified a briefing note was sent to all the provider's locations to minimise the risk of further occurrences.

There was evidence that the practice had learned from incidents, and that the findings were shared with relevant staff. For example, one patient's medicine was changed by a specialist. The GP and the community pharmacist were not made aware of the changes, resulting in the patient receiving the wrong medicine for several days. Following the incident, the systems were strengthened to ensure that all medicine changes were brought to the GP and the pharmacist's attention.

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.

We looked at the records of eight significant incidents. The records were generally completed in a comprehensive and timely manner. However, not all relevant sections had been completed in regards to two incident forms. The business manager agreed to address this issue.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. All staff we spoke with said that they had received recent safeguarding training specific to their role. For example, the GPs had completed level three children's training and relevant vulnerable adults training.

Records we looked at showed that staff had received appropriate training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children, and who to speak to in the practice if they had a safeguarding concern. They were also aware of their responsibilities to share information, record safeguarding concerns and how to contact the relevant agencies. Contact details were accessible.

One of the GPs was the lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware of who the lead was. Records showed good liaison with partner agencies such as the police and social services to share essential information about vulnerable patients. Clinical staff told us they recorded information about patient's welfare in their electronic record.

Records showed that monthly multi-disciplinary safeguarding meetings were held, to share information and discuss children and adults who were considered to be at risk of harm. The children's meetings were attended by GPs, the health visitor, midwife and school nurses.

Good

Are services safe?

Patients' individual records were managed in a way to keep people safe. Records were kept on the SystemOne electronic system, which held all information about the patient.

A system was in place to highlight vulnerable patients on the practice's electronic records, and to ensure that risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The alert system ensured they were clearly identified and reviewed, and that staff were aware of any relevant issues when a patient or their next of kin attended appointments or contacted the practice.

Records showed that the provider issued a safeguarding newsletter to all its services and staff in April 2014. This was sent in response to a serious case review, to share the learning from the incident across the whole organisation.

There was a chaperone policy, which was visible on the waiting room noticeboard and the practice web site (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**)**. Nursing staff and certain administrative staff at the practice had been trained to be a chaperone.

We received assurances that relevant staff that carried out chaperone duties had a satisfactory disclosure and barring (DBS) check. A DBS check helps prevent unsuitable staff from working with vulnerable people, including children. Staff we spoke with were aware of their responsibilities, including where to stand to be able to observe the examination.

Medicines management

Arrangements were in place to ensure that medicines were managed safely and appropriately. Procedures were in place to protect patients against the risks associated with the unsafe use of medicines. For example, the IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

Regular checks were carried out to ensure that medicines were within their expiry date and appropriate for use. Stock rotation systems were also in place to ensure vaccines were within their expiry date and suitable for use. All the medicines we checked were in date. Expired and unwanted medicines were disposed of in line with waste regulations.

We checked medicines stored in the treatment rooms including the medicine refrigerators. We found that medicines were stored securely, and were only accessible to authorised staff.

A policy was in place for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with national guidance.

We saw evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber, and she received regular updates in the specific clinical areas for which she prescribed.

The practice worked closely with the CCG's medicines management team to improve the cost efficiency of medicines and safe prescribing. Records showed that the practice fell within the expected range in all areas monitored by the CCG. Monitoring included patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice.

The new GP lead for the management of medicines was keen to use the Royal College of General Practitioners (RCGP) prescribing indicators, to help minimise adverse effects to patients.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results.

The practice undertook audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The audit trail for controlled drugs did not include a record of who collected the prescription from the reception desk as no signature was required when collecting this. Senior staff took immediate action to address this issue when brought to their attention.

All prescriptions were reviewed and signed by a GP before they were given to the patient. However, we found that

blank prescription forms were not always handled in accordance with national guidance as there was no audit trail identifying which numbered prescription pad had been taken by which clinician. Blank prescription pads were also stored in the doctors' bag, and were available to all staff. Senior staff took immediate action to address this issue when brought to their attention.

Cleanliness and infection control

We observed the premises to be clean and tidy. Cleaning schedules were in place and records were kept, to ensure that the practice was clean and hygienic. Patients we spoke with told us they always found the practice clean, and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to apply infection control measures. The practice had a lead for infection control who had undertaken relevant training to enable them to advise staff on the policy.

Staff we spoke with told us that they received induction training about infection control and refresher updates. Records we looked at supported this.

Records also showed that clinical staff checked the stock supplies of clinical and medical devices at regular intervals, to ensure they were in date, and suitable for use. Various supplies we checked including dressings, syringes and equipment used for minor surgery were in date and sealed, and appropriate for use.

Records showed that an infection control audit was completed on 20 January 2015. The previous audit was completed on 19/03/2014. The reports showed high levels of compliance, and that required remedial actions had been completed. A cold chain audit was also completed in 2015 to check that medicines including vaccines that required to be kept in a fridge were kept at the required temperatures.

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 had a policy for the testing and management of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). Records showed that required control measures and regular checks were carried out in line with the practice's policy, to reduce the risk of legionella infection to staff and patients.

A policy was in place for ensuring that staff were protected against the risks of acquiring Hepatitis B, which could be acquired through their work. All relevant staff were offered Hepatitis B immunisation, which was undertaken by the occupational health staff. We saw evidence in staff files that relevant staff were up to date with their vaccination, and protected from Hepatitis B infection.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. All equipment was tested and maintained regularly, and we saw equipment maintenance logs and other records that confirmed this. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting new staff. We reviewed the personnel files of three members of staff who had been recruited in the last six months. We found that robust recruitment procedures were followed in practice to ensure that new staff were suitable to carry out the work they were employed to do.

The staff files contained information required by law, including proof of identity, references, full employment history, evidence of qualifications and criminal record checks through the Disclosure and Barring Service (DBS).

A policy for checking nurses and GPs qualifications and registration to practice was in place. Records showed that a robust system was in place for ensuring all clinicians remained registered to practice with their professional body, in line with the policy.

Staff told us about the arrangements for ensuring sufficient numbers and skill mix of staff were available to meet patients' needs. They said that there was enough staff on duty to maintain the smooth running of the practice, and to keep patients safe. They covered each other's absences to ensure enough staff were available. The reception staff hours had increased by 12 hours a week to meet the needs of the service.

Good

Are services safe?

We saw there was a rota system in place for the different staff groups to ensure that enough staff were on duty. Records showed that the staffing levels and skill mix were in line with planned requirements.

Monitoring safety and responding to risk

The practice had systems and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, equipment, medicines management, staffing and dealing with emergencies. Records showed that essential health and safety checks were carried out. For example, the lift and fire alarm system were regularly serviced to ensure they worked properly.

Records also showed that all equipment was regularly tested and maintained to ensure it was safe to use. Arrangements were also in place to ensure that the premises were appropriately maintained and safe.

The practice had a health and safety policy, which staff had access to. There was also a health and safety representative. We saw that the practice had completed various health and safety risk assessments, including actions required to reduce and manage the risks.

We saw that staff were able to identify and respond to risks to patients including deterioration in their well-being. For example, procedures were in place to deal with patients that experienced a sudden deterioration in health, and for identifying acutely ill children to ensure they were seen urgently. Arrangements were also in place for patients experiencing a mental health crisis, to enable them to access urgent care and treatment. The practice monitored repeat prescribing for patients receiving high risk medicines.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records we looked at showed that staff had received recent training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice during opening times and all staff knew of their location. However, they were not stored securely overnight, and were accessible to cleaning staff. At the end of the inspection we received assurances that the emergency medicines would be stored securely out of working hours.

The emergency medicines included those for the treatment of common cardiac conditions, anaphylaxis (allergic reaction) and hypoglycaemia (low blood sugar). The practice did not routinely hold stocks of medicines for the treatment of other emergencies. The reason for this was the practice would dial 999 and call an ambulance. Clinical staff assured us that a risk assessment had been completed, and a protocol was in place to manage this.

Processes were also 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.

A comprehensive business continuity plan was in place to deal with a range of emergencies, that may impact on the daily operation of the practice. Actions were recorded to reduce and manage the various risks. Risks identified included power failure, adverse weather, unplanned sickness and access to the building.

A fire risk assessment had been carried out, which included actions required to maintain fire safety.

Records also showed that staff were up to date with fire training, or were due to complete this. Most staff had practised a fire drill in April 2014, to ensure they knew what to do in the event of a fire. The business manager planned to provide two fire drills a year, to ensure that all staff knew the procedure in the event of a fire.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Patients we spoke with told us they received appropriate care and treatment. Senior staff at two care homes we spoke with where patients were registered with the practice, also said that the services were effective.

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

Clinical staff told us that there were opportunities to discuss new guidelines and agree changes to practice, as monthly clinical meetings were held. The advanced nurse practitioner told us that the nursing team and the GPs worked together, to ensure a consistent and effective approach to meeting patients' needs.

Opportunities to develop clinical lead roles in the last 12 months had been limited in view of staff changes. Following the appointment of further staff, the GPs and nurses were looking to take on lead roles in specialist areas such as diabetes, heart disease and asthma, which will enable the practice to focus on specific conditions.

There was a holistic and proactive approach to meeting patients' needs. The staff worked closely with local services and other providers to meet patients' diverse needs. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs, and provided care and treatment in line with NICE guidelines. Patients were referred appropriately to other services on the basis of need.

Management, monitoring and improving outcomes for people

Various staff had key roles in monitoring and improving outcomes for patients, including infection control, medicines management as well as QOF (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The QOF performance data for 2013 to 2014 showed that the practice achieved a total of 96.9%, scoring above the national and local average in 15 out of the 20 clinical areas assessed.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice outcomes were comparable or above other services in the area.

We were shown one clinical audit that had been undertaken in the last year. The audit identified patients over the age of 65 taking aspirin, and a gastric protection medicine to help reduce the risk of side effects. A significant number of patients were found not to be taking a gastric protection medicine. They were prescribed this following the audit and were informed of the reason for this. The lead GP told us of plans to repeat the audit in six months, to demonstrate the changes resulting from the initial audit.

Senior managers acknowledged that limited clinical audits had been completed in the last twelve months, due to the high turnover of GPs at the practice. The new lead GP planned to put an on-going audit programme in place, linked to medicines information, significant events and minor surgery. This will help to improve the outcomes for patients, and provide assurances as to the quality of care.

The practice was applying the gold standards framework for end of life care, focusing on advanced care planning and holistic care, and reviewing the care provided for patients.

Effective staffing

We found that the practice had a motivated team that worked well together. Various staff had worked at the practice for a number of years, which ensured continuity of care and services. However, there had been a high turnover of GPs and use of locums in the last 12 months, which had led to patients not receiving care from GPs they knew and trusted.

We found that the staffing situation, and continuity of patients care had improved over recent months, following the appointment of three fulltime salaried GPs. One of the GPs had considerable experience and had been appointed the lead clinician. In addition, the GP hours had increased from 2.3 to 3 whole time equivalents to ensure the services were effective.

The practice also had two new additions to its nursing team. Both members of staff said they had received an

Good

Are services effective?

(for example, treatment is effective)

induction specific to their role, to enable them to carry out their work. The induction was supported by an up to date staff handbook, which contained various key policies along with essential information and guidance for staff. Their induction was over a four week period, which they found helpful. Both staff members said they felt well supported. For example, they had been given extended appointment times to familiarise themselves with the practice's processes and procedures.

Records showed that staff had attended various training relevant to their role. This included mandatory training such as infection control, fire safety and basic life support. A monthly protected learning event was held, which staff were supported to attend.

The practice had a good skill mix of staff to ensure the services were effective. For example, the lead GP had completed various diplomas including child protection, minor surgery, diabetes, asthma, family planning and anticoagulation among their skills and experience.

Our interviews with staff confirmed that the practice actively supported and funded staff to attend relevant training, to develop their skills and meet patients' needs. For example, one of the GPs was due to undertake training to enable them to carry out vasectomy procedures at the practice.

The advanced nurse practitioner undertook various extended roles and was able to demonstrate that they had received appropriate training to undertake these. Her standard appointment times had been extended from 10 to15 minutes, to enable her to carry out her role effectively. She had also been allocated an additional 2.5 hours a week, to complete administrative duties and support the nursing team.

New staff were also supported to attend relevant training to develop their skills and meet patients' needs. Since taking up post in January 2015, the healthcare assistant (HCA) had received training to enable her to take patients' blood pressure, complete new patient health checks as well as use the electrocardiogram to record the rhythm and electrical activity of a patient's heart. They were also being supported to undertake B12 injections and anticoagulant testing. They told us they were observed undertaking the above procedures to ensure they were competent to carry out the tasks. We saw that completed records to support this.

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

Working with colleagues and other services

Our findings showed that the practice worked closely with other service providers and staff to meet patients' needs. The practice held monthly multi-disciplinary meetings, to discuss the needs of adults with complex needs or at risk of unplanned admissions to hospital. This helped to ensure that patients and families received coordinated care and support, which took account of their needs and wishes. The adult meetings were attended by district nurses, social workers, community matron, care-coordinator and other professionals involved in patients care.

The practice kept a register of patients receiving end of life care. Monthly palliative care meetings were held, to discuss the care and support needs of patients and their families. All relevant staff involved in their care including GPs, district nurses and Macmillan nurses attended the meetings.

Monthly children's meetings were also held to discuss all patients in vulnerable circumstances and at risk of abuse. These meetings were attended by health visitors and school nurses.

Decisions about patients' needs were documented in a shared care record. Staff felt the systems worked well and provided a means of sharing important information.

The practice held various internal meetings to share information and best practice. These included monthly nurses and clinical meetings, two monthly administrative meetings and quarterly whole team meetings.

Information sharing

A system was in place to coordinate records and manage patients' care, and enable essential information to be saved and shared in a secure and timely manner. The system enabled scanned paper communications, such as those from hospital, to be saved for future reference

Good

Are services effective?

(for example, treatment is effective)

Staff used an electronic patient record called SystmOne to coordinate, document and manage patients' care. The practice received test results, letters and discharge summaries from the local hospitals and the out-of-hours services both electronically and by post.

A policy was in place outlining the responsibilities of relevant staff in passing on, reading and acting on any issues arising from communications with other providers. We saw that test results, information from the out-of-hours service and letters from the local hospitals including discharge summaries were promptly seen, coded and followed up by the GPs, where required.

Electronic systems were in place to enable referrals to other providers be made promptly. Records showed that 84% of referrals made in the last 12 months were through the Choose and Book system. (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) The practice was signed up to the electronic Summary Care Record, which provides faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

Consent to care and treatment

Patients told us that they were involved in decisions and had agreed to their care and treatment.

Clinical staff told us that they obtained patients' informal consent before they provided care or treatment. There was a policy for obtaining written consent for specific interventions such as minor surgical procedures, together with a record of the benefits and possible risks and complications of the treatment. We saw evidence that formal consent had been obtained for patients who received minor surgery.

Clinical staff were aware of the Mental Capacity Act 2005, and understood their duties in fulfilling it. They understood the key parts of the legislation and were able to describe how they implemented it in their practice. Records were not available to show that all staff had received relevant training to ensure they understood how they applied this in their practice. The business manager agreed to follow up this issue, to ensure that all staff received the training.

Staff told us that patients who lacked capacity with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in circumstances required it. Staff gave examples of how a patient's best interests were taken into account if they did not have capacity to make a decision.

Health promotion and prevention

Patients we spoke with told us the GPs and nurses gave them advice and guidance about maintaining a healthy lifestyle. We saw that a range of health promotion information was available to patients and carers on the practice's website, and the noticeboards in the waiting area.

We found that patients were educated and supported to self-manage their conditions, to improve their compliance and live healthier lives. For example, patients with hypertension were invited to sign up to a self-monitoring service, which helped them to monitor their condition remotely without having to attend the practice regularly. Various patients had signed up to this. The advanced nurse practitioner told us that she had attended recent training, on empowering patients to make decisions and self-manage their conditions.

It was practice policy to offer a health check with the health care assistant 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.

We noted a culture among the clinical staff to use their contact with patients to help maintain or improve their wellbeing and physical and mental health. For example, the clinical staff offered smoking cessation support to patients over the age of 16. There was evidence these were having some success as data showed that 141 patients had stopped smoking in the last 12 months.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. Data showed that 370 patients (40%) in this age group took up the offer of the health check.

Records showed that 60% of older people discharged from hospital since 1 January 2015 had had a follow-up consultation. The follow-up rate of people with poor mental health who had attended A&E was 37%. Clinical staff were working to improve this.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in

Good

Are services effective?

(for example, treatment is effective)

offering this. The practice kept a register of patients with a learning disability, experiencing poor mental health, those in vulnerable circumstances, with long term conditions and older people. They were offered an annual health check, including a review of their medicines**.** For example, the practice had 26 patients registered with poor mental health. Of these, 20 had been offered an annual health check so far, and 10 had taken up the offer. One elderly patient we spoke with could not recall having been offered an annual health check.

The practice was involved in a wide range of screening programmes including bowel, breast and cervical screening. Data showed that 86% of women aged 25 to 65 years had received a cervical screening test in the last 5 years, which was above the national average (82%).There was a policy to offer reminders for patients who did not attend for cervical smears.

Patients could self-refer to mental health, drug and alcohol teams. The practice also had links with the mental health crisis team. The practice screened appropriate patients for dementia, resulting in early referral and diagnosis where dementia was indicated.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The 2013 to 2014 data for all childhood immunisations showed that the practice was achieving above the CCG average rates for the majority of vaccinations.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients told us the staff were friendly, caring and considerate and treated them with dignity and respect. They also said that they felt listened to and that their views and wishes were respected

Senior staff at two care homes we spoke with where patients were registered with the practice, also said that the practice staff were caring and treated patients with dignity and respect.

Staff and patients told us that consultations and treatments were carried out in the privacy of a suitable room.

We noted that conversations could not be overheard. We observed that patients were treated with dignity, respect and kindness during interactions with staff. Patients privacy and confidentially was also maintained. Confidential information was kept private.

We reviewed the most recent data available for the practice on patient satisfaction. This included the 2015 national patient survey, and the practice's 2013/2014. survey**.** This showed that patients were treated with care, dignity and respect.

For example, the national patient survey showed that 91% of people had confidence and trust in the last GP they saw or spoke to, and 81% said that they were good at listening to them. Their satisfaction in these areas when they saw a nurse was slightly higher. All results were higher than the local Clinical Commissioning Group (CCG) average.

The practice performed less well in the following areas: 42% with a preferred GP said that they usually get to see or speak to that GP, 77% said the last GP they saw or spoke to was good at treating them with care and concern and 77% said they were good at explaining tests and treatments. These results were below the local CCG average.

A notice was displayed in the patient reception area stating the practice's zero tolerance for abusive behaviour. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the business manager.

We also reviewed the patient reviews of the practice on NHS Choices, completed in the last 12 months. Five out of nine comments were very positive about the care and treatment patients received. Negative comments mostly related to the turnover of GPs, lack of continuity of care and the conduct of certain locums.

Care planning and involvement in decisions about care and treatment

Patients said that they felt listened to, and were involved in making decisions about their care and treatment. They were given sufficient time and information during consultations to enable them to make informed choices. late.

The 2015 national patient survey showed that 80% of people said that the last GP they saw or spoke to, was good at giving them enough time, 78% said that they were good at involving them in decisions about their care, and 77% said that they were good at explaining tests and treatments. Their satisfaction in these areas when they saw a nurse was slightly higher. All results were higher than the local Clinical Commissioning Group (CCG) average.

Clinical staff told us that patients at high risk of unplanned admissions to hospital, including elderly patients and those with complex needs, or in vulnerable circumstances, had a care plan in place to help avoid this. The care plans included patient's wishes, including decisions about resuscitation and end of life care

Patient/carer support to cope emotionally with care and treatment

The above survey information showed that patients were positive about the emotional support provided by the practice and rated it well in this area. Patients we spoke with and comment cards we received, were also consistent with the survey information. Patients told us they were supported to manage their own care and health needs, and to maintain their independence, where able.

Carers' details were included on the practice's computer system, to alert staff if a patient was also a carer to enable them to offer support.

We noted that information was available to carers in the patient waiting room on how to access a number of support groups and organisations. The practice's website did not include information for carers.

Good

Are services caring?

Staff we spoke with demonstrated that importance was given to supporting carers to care for their relatives, including those receiving end of life care. Bereaved carers known to the practice were supported by way of a personal visit or phone call from a GP who knew them best, to determine whether they needed any practical or emotional support. We did not speak with any bereaved patients to establish the level of support they received.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Comments received from patients showed that the practice was responsive to their needs.

We spoke with senior staff at the two main care homes where patients were registered with the practice. They told us that the practice was responsive to patients' needs.

As part of the enhanced services, the main care homes where patients were registered with the practice, were visited each week by the practice's advanced nurse practitioner. The GPs also had regular contact with the care home and visited patients as required. The pro-active approach provided continuity of care and ensured that patients are reviewed regularly, to help prevent unplanned admissions to hospital and health issues from becoming more serious.

We found the services were responsive to patients' needs. The practice knew the needs of their patient population well. The services were flexible, and were planned and delivered in a way that met the needs of the local population. For example, 102 patients were on warfarin, which is a medicine that helps reduce blood clots. Patients were required to have regular blood tests to monitor the effects of warfarin. To enable them to have the tests done locally, the practice had purchased testing equipment and relevant staff had received training to undertake this.

The practice engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice was involved in a winter pilot, which offered same day urgent walk-in appointments on Monday and Friday mornings. This was part of the Prime Minister's Challenge Fund to improve patient access to primary care.

The practice was signed up to provide enhanced services for patients with dementia, and proactively screened patients to help facilitate early referral and diagnosis where dementia was indicated.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its services. Staff told us the practice accepted new patients who lived within their practice boundary. They also provided temporary registration and treatment to patients, where required.

Home visits and longer appointments were available for patients who needed them, including people in vulnerable circumstances, experiencing poor mental health, with complex needs or long term conditions.

The practice was situated on the ground floor of the building. The premises were accessible and adapted to meet the needs of people with disabilities. There were wide corridors and doors, to enable access for people with restricted mobility including wheelchairs, or mothers with prams or pushchairs. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

For patients who were registered blind or deaf, an alert was in place on the computer system to alert staff to their needs and support they may require.

The practice had a 97% white British population. The practice had access to online and telephone translation services, and information was available on the practice web site and in the waiting room. In addition any leaflets at the practice could be printed out in different languages.

The practice provided equality and diversity training. Staff we spoke with confirmed that they had received recent training, and that equality and diversity issues were regularly discussed at appraisals and team events. We saw evidence of this.

Access to the service

Patients told us they were able to access the service when they needed to. Comments from patients identified there had been problems with the appointment system, although access had improved. Comments showed that patients were usually able to make an urgent appointment or request a telephone consultation the same day. However, several patients said that it could take up to two weeks to get a non-urgent appointment.

The national GP survey published in January 2015 showed that 83% of people who completed this described their experience of making an appointment as good, 90 % said they were able to get an appointment to see or speak to a

Good

Are services responsive to people's needs?

(for example, to feedback?)

clinician the last time they tried and 75% said that they found it easy to get through to the surgery by phone. These results were above the local Clinical Commissioning Group (CCG) average.

The practice opening times were from 08.00 am to 6.30 pm Monday to Friday. Outside of the practice opening hours patients could contact the out-of- hours service, which was provided by Central Nottinghamshire Clinical Services.

We saw that the information about the appointment system, opening times and the out-of-hours service was available in the reception area and on the practice's website. If patients called the practice when it was closed, an answer phone message gave the telephone number they should ring depending on the circumstances.

We found that the appointment system was flexible to meet the needs of patients. Staff offered patients a choice of appointments to meet their needs, where possible. We saw that systems were in place to prioritise emergency and home visit appointments, or phone consultations for patients who were not well enough to attend the practice. Staff added patients who needed to be reviewed urgently to the appointments to be seen that day, or arranged for a call back from a GP, where appropriate.

Longer appointments were also available for patients who needed them including vulnerable patients**,** those experiencing poor mental health, with a learning disability or long-term conditions.

The practice was restricted from offering extended opening hours by the terms of the building lease agreement, in which the practice was located.

As part of a winter pilot, the practice offering same day urgent walk-in appointments on Monday and Friday mornings, to improve patient access to the service. The chair of the Patient Participation Group told us that this was the only GP practice in Newark to offer this service, which was proving beneficial to patients. To enable the practice to manage the numbers of patients attending the urgent walk-in service, patients were now given a specific hour to attend.

The business manager told us that they regularly reviewed the appointment system and telephone response times, to ensure it met the demands on the service. We saw evidence of this.

Listening and learning from concerns and complaints

Patients said they felt listened to and were able to raise concerns about the practice. Not all patients were aware of the process to follow should they wish to make a complaint, but they said that they had not had cause to do so. We noted that limited information was available to patients to help them to understand the complaints procedure on the practice's website.

The practice's complaints procedure was in line with current guidance and the NHS procedure for GPs in England. However, we noted that information about the complaints procedure on the practices website and the leaflet available to patients at the practice, did not state that they could direct their complaint to NHS England rather than the practice, in addition to contacting the Parliamentary Health Service Ombudsman to investigate second stage complaints.

A system was in place for managing complaints and concerns. The business manager was responsible for handling complaints. They told us that they had recently attended a course on managing complaints. Where possible, concerns were dealt with on an informal basis and promptly resolved.

The complaints log showed that the practice had received 21 formal complaints in the last 12 months. This recorded what each complaint related to, which helped the business manager to consider any trends and patterns. There had been an earlier theme of complaints about access to appointments and a clinician's conduct. We found that the practice had taken appropriate action to address the issues.

Records we looked at showed that complaints had been acknowledged, investigated and responded to in line with the practice's policy. The records indicated that appropriate learning and improvements had taken place. The business manager sent details of complaints received each month to the provider, to oversee that they had been responded to appropriately.

Staff told us that the practice was open and transparent when things went wrong, and that patients received an apology when mistakes occurred. Complaint responses we reviewed indicated that patients had received an apology, where appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Staff told us that there was a culture of openness and that they were encouraged to raise concerns. They also said that any concerns were shared with staff at team meetings, and were acted on to improve the service for patients. Records we looked at supported this.

Are services well-led?

Good

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

Our findings

The practice had a mission statement, which was: 'To improve the health, well-being and lives of those we care for.' This was displayed on the practice website, and displayed in the waiting room at the surgery. Staff we spoke with understood the values and aims of the service, and what their responsibilities were in relation to these.

A business plan for 2015 to 2016 was in place, which set out the short term plans and demonstrated a commitment to on-going improvement. This was monitored and regularly reviewed by senior managers. The business manager told us that the plan covered one year, as the practice's contract to provide services was due to be renewed in 2016.

Governance arrangements

The provider had a wide range of policies and procedures in place to govern the practice. A system was in place to ensure that the policies were regularly reviewed and were up-to-date, and shared with staff. Nine key policies we looked at had been reviewed recently and were up to date. We found that the policies were followed in practice.

We found that effective systems were in place for gathering and reviewing information about the quality and safety of services that people received. Systems were in place for identifying, recording and managing risks. Various risk assessments had been completed; where risks were identified action plans had been implemented to minimise the risks.

Records showed that various meetings took place to aid communication and the sharing of essential information. For example, monthly clinical meetings were held to share knowledge and learning between the GPs and nurses. Monthly nurses meetings were also held to discuss nursing issues.

We saw that the practice had completed various audits to monitor and improve the quality of care and services for patients. However, limited clinical audits had been completed in the last twelve months, due to the high turnover of GPs. The new lead GP planned to develop the clinical audit programme, linked to medicines information, safety alerts and significant events, to monitor the quality of care and identify where improvements were needed.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for 2013 to 2014 showed that the practice achieved a total of 96.9%, scoring above the national and local average in 15 out of the 20 clinical areas assessed. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

There had been significant changes to the clinical team in the last 12 months. The practice was undergoing a settling period following the appointment of new staff. The clinical leadership had been strengthened following the appointment of three salaried GPs in the last six months, one of which had been appointed the clinical lead.

The practice had a clear leadership structure. All staff had lead roles and responsibilities to ensure that the service was well managed. Staff we spoke with were clear about their own roles and responsibilities, and felt that the practice was well led. They also said that they felt valued, well supported, and involved in decisions about the practice.

Staff said that they enjoyed their work and that morale was good. The culture of the organisation was open, and they felt able to raise any issues with senior staff as they were approachable. The business manager had an 'open door' policy to discuss any concerns or suggestions. A whistleblowing policy was in place and staff were aware of this, but they had not had cause to use it.

Records showed that regular team meetings were held, which enabled staff to share information and to raise any issues.

Seeking and acting on feedback from patients, public and staff

The practice obtained feedback from patients through surveys, comments and complaints. The practice and the PPG issued an annual satisfaction survey to patients. We looked at the 2013/2014 survey results, which 57 patients completed. The results were mostly very positive The results and actions agreed from the recent satisfaction surveys were available at the practice and on the web site.

The practice had an active Patient Participation Group (PPG), which is group of patients who work with the practice to represent the interests and views of patients, to improve the service provided to them.

Are services well-led?

Good

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

We spoke to the chair of the PPG. They told us the practice valued the PPGs role, and worked with them to improve the services for patients. For example, in response to patients concerns that it took too long to get through to the practice on the telephone, a new phone system was recently installed. This had improved access. The PPG produced a monthly newsletter for patients, which included information about changes at the practice. The information was available to patients.

The practice and the PPG had held an open day for patients in October 2014, to enable patients to provide feedback about the services, and meet the three new permanent GPs. Various people attended the open day to provide advice including Age UK, and staff from NHS England and the local Clinical Commissioning Group.

Management lead through learning and improvement

The commitment to learning and the development of staffs' skills was recognised as essential to ensuring high quality care. Staff told us that they were actively supported to acquire new skills and develop their knowledge to improve the services. For example, the nurse practitioner was also being funded to commence a degree in diabetes in September 2015.

Records we looked at showed that staff received on-going training and development, and an annual appraisal to enable them to provide high standards of care. Staff appraisals set out learning and development needs, from which action plans were documented.

The practice had completed reviews of incidents and significant events and shared the findings with staff at meetings, to ensure lessons were learnt and improvements had taken place to minimise further incidents. For example, GP hours were increased and a data quality administrator was appointed, following complaints that letters and reports from other professionals had not been seen and actioned in a timely manner.