The Maltings 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Maltings Surgery on 22 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long-term conditions, people whose circumstances make them vulnerable, families, children and young people, working people and those who have recently retired and people experiencing poor mental health.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

There was an area of practice where the provider needs to make improvements.

The provider should:

Summary of findings

- Consider a more robust mechanism to communicate with locum GPs to inform them of changes in the practice following practice meetings.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood 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.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above 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.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and urgent appointments were 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. There was evidence of learning from complaints.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings which included governance. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for 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 practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks and offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health were offered an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Prior to our inspection we left comment cards at the practice for patients to complete and give their views regarding the service they received. Fifty-two patients had completed cards with the majority reporting positive experiences and a high level of satisfaction with services and treatment at the practice. Patients remarked on being treated with kindness and that they were listened to and treated respectfully. We saw specific reference to several GPs where patients considered they had provided care in excess of what was required. As a result, they reported they had received better outcomes and some patients commented that their quality of life had improved as a result of excellent care.

Patients commented on the benefit of the extended hours appointments, that help and advice for young children was good and that the practice had been responsive during times when urgent care and advice was needed. Positive comments had been made regarding all staff groups in the practice, including reception and administrative staff, nursing staff and GPs.

During our inspection we spoke with eight patients who expressed similar views to those recorded on the comment cards. Patients told us that they found the practice offered a very good service and that staff were caring and helpful. Four of the patients we spoke with during our inspection told us they always found it easy to get appointments and had called that morning for an appointment.

The few negative comments we saw on comment cards referred to the difficulty experienced getting through on the telephone. Patients we spoke with told us there had been difficulties in the past with the telephone system but that this had recently been resolved and they had noticed improvements when trying to get through on the telephone. Some patients remarked that it did take longer to get an appointment with a preferred doctor.

Areas for improvement

Action the service SHOULD take to improve

- The practice should consider a more robust mechanism to communicate with locum GPs to inform them of changes in the practice following practice meetings.

The Maltings Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a practice manager specialist advisor.

Background to The Maltings Surgery

The Maltings Surgery is a GP practice providing general medical services to a practice population of approximately 18,100 who live in the centre and surrounding areas of St Albans. The practice is situated in the centre of St Albans and provides services under a general medical services contract (GMS). The practice operates in a two-story building providing services from the ground and first floor levels. There are eight GP partners, three female and five males, and four female salaried GPs. They also employ five practice nurses, two health care assistants, a practice manager and reception manager who are supported by a team of reception and administrative staff. A variety of additional staff from the local health care trust attend the practice to provide services such as midwifes, health visitors and counsellors.

The practice is a training practice which has three trainers and two associate trainers. They have a qualified doctor each year who they support to gain experience in general practice.

When the practice is closed services are provided by an out of hours provider that can be accessed via the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out this inspection 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 surgery 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.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 22 April 2015. During our inspection, we spoke with a range of staff, including the practice manager, reception manager, GPs, nurses, health care assistants, reception and administration staff. We also spoke with patients who used the service and observed how staff responded and helped patients, their relatives and carers when they attended the practice. We also spoke with the chair of the patient participation group (PPG) who shared with us how the practice engaged with patient representatives. A PPG is a group of patients who represent the views of patients and work with the practice to make improvements as a result of patient feedback.

Good

Are services safe?

Our findings

Safe track record

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. The locum GP we spoke with was also aware of the need to report any concerns and told us they would do this via the practice manager. The practice used a range of information to identify risks and improve patient safety such as incident reports and national patient safety alerts as well as comments and complaints received from patients. We saw that these had been identified and actioned appropriately and shared with the staff.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

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 year and we were able to review these. We saw that these had been investigated and outcomes shared with all relevant staff from minutes of meetings made available to us. Both clinical and non-clinical events had been reported and discussed. When a significant event had occurred the secretary would input this onto the agenda for the next meeting. There was evidence from minutes of meetings that the practice had learned from these and that the findings were shared with relevant staff. Staff we spoke with confirmed this learning. Staff, including receptionists, administrators and nursing staff told us there was an open and honest culture in the practice and they felt comfortable to raise any concerns or issues for consideration at practice meetings and they were encouraged to do so.

The staff showed us the incident forms on the practice intranet and told us these were completed and sent to the practice manager. They were also available in paper form. They showed us the system used to manage and monitor incidents and we tracked some incidents and saw that staff had recorded events accurately and comprehensively in a timely manner. We noted that the practice had taken action when changes were recommended as a result of the investigation. For example, we saw that an education session had taken place for clinicians following a significant event which had identified an update of knowledge in a specific area was required. 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.

National patient safety alerts were disseminated by the lead nurse to the appropriate practice staff where necessary. The salaried GP we spoke with was able to give an example of recent alerts that were relevant to the care they were responsible for. Staff also told us that if any alerts were appropriate and necessary to be shared to all staff, then they would be discussed at a practice meeting.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children who had received the necessary training to enable them to fulfil this role. We saw flow charts in several areas of the practice informing staff of the procedure to follow should they have any concerns regarding safeguarding. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records and the nurse told us they utilised this system. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the health visitor. We saw evidence from meetings to show that

specific patients with safeguarding concerns had been discussed. We also spoke with the health visitor who attended the practice from the local primary care community trust who told us that communication from the practice was good regarding safeguarding and they attended meeting and discussed any concerns. They also told us they felt they could contact the GPs at any time with any concerns regarding patients and were invited to attend the informal coffee mornings which enabled all staff to discuss any issues on a daily basis. They also had a direct line to the practice to contact them if they needed to. The health visitor also told us they left non-urgent messages in a book in reception to communicate to specific doctors when necessary which they reported worked well.

There was a chaperone policy and we saw posters were on display in the surgery advertising this facility. (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). We saw the practice training matrix which showed a significant number of reception staff had been trained to chaperone if necessary. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. The practice had undertaken a risk assessment and made a decision that reception staff would at no time be left alone with patients and therefore, would not require a DBS check. This had been discussed by the practice and was reflected in the chaperone policy. We saw minutes of the meeting which included this discussion.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy 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.

One nurse demonstrated the clear computerised system and process which was in place to check stock of medicines and that they were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records to show that the practice had changed prescribing of a specific antibiotic in response to new guidance from the local prescribing advisors and subsequent audit.

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

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. There was a member of staff responsible for ensuring this took place and appropriate action was taken based on the results.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and we looked at these and saw they were kept securely and signed for when removed from the cupboard.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. The reception manager told us they also carried out regular spot checks to ensure the standards were being maintained. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out an audit recently and identified actions, which had been completed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Good

Are services safe?

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 management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice had commissioned a Legionella assessment from an external company and that work had been completed as a result to meet the recommendations.

Equipment

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

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had commissioned the services of a recruitment company to manage their human resources policies and we saw that these were appropriate and they had a recruitment and induction policy that set out the standards it followed when recruiting clinical and non-clinical staff.

The practice manager told us there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place that only two members of staff could be off at any one time and this was covered in the main from overtime by existing staff.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. We noted that staff were trained to carry out various other tasks, for example scanning, reception and prescriptions which enabled them to cover safely when required.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy which we saw was up to date. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were monitored individually such as a maintenance log, fire assessment log, infection control. Each risk was assessed and mitigating actions recorded to reduce and manage the risk. The practice manager told us that any risks identified would be shared at the practice meeting where necessary.

The practice offered on the day appointments to deal with any patients who needed to see a doctor urgently, and four patients we spoke with that day told us they had called that morning, as they needed an urgent appointment. The practice had a separate line for the district nurses, palliative care nurse and health visitor to contact the surgery urgently.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We looked at training records which showed that all staff had received 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. During our inspection we noted a patient in the waiting area who was experiencing difficulty breathing and needed urgent attention. We saw the practice manager noticed this and dealt with the situation quickly and directed them to the appropriate medical person with a satisfactory outcome.

Good

Are services safe?

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. We saw the practice had a process 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 business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that the practice had six staff trained as fire marshals, and that a fire drill had been carried out in November 2014. We saw that most of staff were up to date with fire training and those outstanding were scheduled for June 2015. All staff had fire training on induction and a tour of the building alerting them to the fire equipment and exits.

Risks associated with service and staffing changes (both planned and unplanned) were included on the practice risk log. An example of this was the use of liquid nitrogen, and legionella and the mitigating actions that had been put in place to manage this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All clinical staff we spoke with were able to demonstrate 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. The practice assigned a GP each month to check for NICE guidance updates which were summarised and discussed at a monthly education meeting. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines and other best practice guidance, and these were reviewed when appropriate.

Staff we spoke with told us that GPs lead in specific clinical areas such as diabetes, heart disease, asthma and mental health. The practice nurses also focused on conditions such as diabetes, chronic obstructive pulmonary disease (COPD) and asthma to support this work and ensured that long term conditions were managed systematically. All staff we spoke with reported being open about asking for and providing colleagues with advice and support and this was facilitated by regular educational sessions and informal coffee morning meetings Tuesday to Friday. GPs told us this supported all staff to continually review and discuss new best practice and share experiences and ideas regarding delivery of care. Discussions with all clinical staff confirmed this happened.

The GPs told us they operate a buddy system for support and advice, and they were currently using this to ensure that blood and x-ray results and hospital correspondence were recorded correctly into patients' records and there were no omissions.

Data from the local CCG of the practice's performance for antibiotic prescribing was made available to us, which was comparable to similar practices. They had carried out an audit to determine if changes were needed but concluded they were not and plans were made to repeat the audit soon.

The practice did not use computerised tools to identify patients with complex needs but carried out searches of the disease registers to identify these patients. We were shown the process the practice used to review patients recently discharged from hospital, which showed that the discharge summary was sent to the patients named GP who reviewed care and arranged follow up as required.

National data showed that the practice had slightly higher referral rates to secondary care compared with the national average, although their rates were comparable with other practices locally. The practice was beginning to use templates and pathways which were being set up by the local clinical commissioning group.

We saw there was no discrimination when making care and treatment decisions and interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. The practice told us they provided additional support for particularly vulnerable patients with complex needs, making use of a variety of support organisations to help patients. We noted case studies from six patients where the practice had organised meetings and input from other organisations such as social services, mental health, district nursing and secondary care consultants and staff to help patients come to terms and manage their conditions and which resulted in an improved outcome and a better quality of life.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. For example, the administration staff are responsible for recalling patients for GPs and nurses carry out routine chronic disease management and immunisation. This information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

Good

Are services effective?

(for example, treatment is effective)

The practice showed us five clinical audits that had been undertaken in the last two years. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, there had been an improvement in the identification of patients who required their blood pressure monitoring when taking a specific medication. Another example included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance. This had resulted in an improved level of documented consent to procedures.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (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). We saw evidence of a GP who had reviewed medication with a patient in response to a recommendation for change by the CCG and had carried out the appropriate assessment but had kept the current medication for the patient as it was more appropriate treatment for their circumstances.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice met all the minimum standards for QOF in all long term conditions such as asthma, chronic obstructive pulmonary disease (lung disease). They had a high QOF achievement overall and had gained maximum points in all areas except diabetes, but had still exceeded the QOF achievement in diabetes than that of the national and local CCG average.

The team used clinical audit, clinical supervision and staff and educational meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. We saw that the IT system flagged up relevant medicines alerts when the GP was prescribing medicines. A discussion with one GP demonstrated that after receiving an alert, they had reviewed the use of a specific medicine and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had an oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. We noted from discussions with staff and from minutes of meetings that communication was effective in the practice regarding care.

One of the GP partners in the practice was a member of the local clinical commissioning group and fed back to the practice information regarding changes and local initiatives being implemented. 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.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the GPs who covered a variety of conditions with their specific interest and a number having additional diplomas in sexual and reproductive medicine, children's health and gynaecology. One of the GP's was also the lead for the practice and the CCG in mental health. The 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).

Good

Are services effective?

(for example, treatment is effective)

Staff we spoke with told us that they had annual appraisals that identified learning needs and confirmed they had personal development plans as a result of this process. We also saw staff records that confirmed this. Interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example training in cervical cytology and immunisation. The practice was a training practice and patients who saw doctors who were training to be qualified as GPs were offered extended appointments of 30 minutes and a specific GP was allocated with time set aside to provide supervision, support and a de-brief following consultations. We spoke with a trainee GP at the practice who told us they had been very well supported throughout their training. They commented on how the practice had been particularly encouraging and supportive to them during a period of ill health which they had found very beneficial.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. We saw that the nurses who were responsible for care of patients with long term conditions such as asthma, diabetes and chronic obstructive pulmonary disease had received additional training and had diplomas in those conditions.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. We saw a significant amount of evidence of contact with other agencies such as social services, secondary care consultants, mental health teams, specialist nursing teams and carers and staff from the local homeless shelter, which had resulted in improved health outcomes for patients and a better quality of life. For example, we saw evidence of how a multi-disciplinary approach and frequent communication with all services involved had helped a patient come to terms with their condition, develop an understanding of how to manage their symptoms and enabled them to recognise their potential to take control of their life.

The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. They operated a 'buddy' system for when a GP was away from the practice for longer than 48 hours, in that their 'buddy' would ensure their results were acted on. All staff we spoke with understood their roles and felt the system in place worked well. There had been one incident when a result had been missed in the last year, but the practice had investigated this as a significant event and put measures in place to prevent a recurrence.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for acting on hospital communications was working well in this respect.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, palliative care nurses and the health visitor and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. We saw minutes of the meetings which took place and saw that information was stored in a shared care record.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared, such as for patients who did not require resuscitation, or sharing information regarding patients receiving palliative care.

Electronic systems were also in place for making referrals, and the practice made referrals 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). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take

Good

Are services effective?

(for example, treatment is effective)

with them to A&E which showed information of the five most recent consultations, medications and investigations. The practice has also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 (MCA) and their duties in fulfilling it. Almost all of the GPs had received MCA training and there were plans for all staff to receive the training during their next allocated training day. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. The GPs told us about specific scenarios when they had been required to challenge other peoples judgement on capacity, where they had found the patient to have capacity following formal assessment and we saw anonymised written evidence which confirmed this.

Patients 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. We saw that 86% of patients with a learning disability had received a face to face review. All staff were aware of the folders which were provided to give information to patients with learning difficulties. Care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, we saw verbal consent was documented for joint injections in patients' records and when GPs carried out minor surgery consent forms were used and scanned into the records.

Health promotion and prevention

The practice had engaged with the local CCG to discuss the implications and share information about the needs of the practice population identified by a variety of sources. This information was used to help focus on health promotion activity.

Health checks with the health care assistant (HCA) were offered to all new patients registering with the practice who had a long term condition or who required specific interventions and reviews. The HCA informed the GP of any health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. We saw several examples of thorough assessment and liaison with other professionals to address specific issues and signposting to other services, for example, mental health support services.

NHS Health Checks were offered to patients aged 40 to 75 years and we saw they had actively offered these to 1,847 patients. Practice data showed that 30% of patients in this age group had taken up the offer of the health check.

The practice had numerous ways of identifying patients who needed additional support and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and 77 out of 91 received an annual physical health check. There were two specific GPs who carried out assessments for patients with learning disabilities and who also visited the local learning disability care homes providing continuity of care.

The practice had also actively offered nurse-led smoking cessation support to 91% of patients over the age of 15 who had been recorded as a smoker. This was provided from their own smoking cessation sessions in-house.

The practice's performance for cervical cytology uptake was 89%, which was better than others in the CCG area and those nationally. The nurses told us they audit their

Good

Are services effective?

(for example, treatment is effective)

inadequate cervical cytology which showed their rates were very low. The practice offered chlamydia screening to all patients 16-24 years and discussed this at family planning consultations.

A full range of immunisations for children was offered as well as travel and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was 96.4% which was similar to that of other practices in the CCG. They also provided a six week medical check for babies prior to their first immunisation.

The practice had been proactive in promoting bowel screening and had invited 1,329 patients to participate in the screening.

The practice kept a register of patients who were at high risk of admission. Any patients who were admitted were reviewed and additional support was offered where necessary. The practice reported they had contacted approximately 50 patients in the last six months and reviewed their care. They had a dementia champion who provided in-house training to staff and was working to identify more undiagnosed patients through clinical system searches. There was also a dementia screening reminder in clinical rooms to promote awareness.

The practice operated personal patient lists and a 'buddy' system to cover in times of annual leave to promote continuity of care for patients particularly those with complex needs. We saw evidence of good communication with the multi-disciplinary team which promoted coordinated care.

We saw there was a robust system in place to call and recall patients with mental health and other chronic long term conditions for a review of their physical health. We noted that one GP was the lead clinician for the area on mental health and was a resource for the practice in this area of care providing advice and information regarding local services.

The practice hosted sessions from the local Improving Access to Psychological Therapies (IAPT) for patients who required additional support with mental health issues. This meant they were able to refer patients who required this service easily.

Annual meetings with the local consultant in diabetes took place to allow discussions regarding best practice and we saw that 40 out of 41 newly diagnosed patients with diabetes had been referred for structured education sessions regarding their condition. We noted that the practice had a lower than the CCG average number of patients over the age of 40 who had a recording of their blood pressure in the last five years. However, data showed blood pressure monitoring of patients with diabetes was slightly better controlled than that of other practices in the CCG and nationally. We also saw the practice had been carrying out audits in blood pressure management as a result of a change in NICE guidance.

The practice told us that staff who summarised the hospital discharge information alerted the GPs to any patients who may have had a fragility fracture and who may have needed referral for a DEXA scan. (A DEXA scan is a special type of X-ray that measures bone mineral density)

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction which was from the National Patient Survey 2014 and also from a survey the patient participation group (PPG) had carried out in April 2015. The evidence from all these sources showed a high level of satisfaction from patients generally regarding how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed that 81% of patients had rated the practice as good or very good. We also saw from the national survey that 89% of patients reported satisfaction with how the GPs listened to them and 81% thought the GPs were good at giving them enough time. The survey carried out by the PPG aligned with these responses with 91% of respondents reporting they were either very satisfied or satisfied with the general quality of care from the practice.

We reviewed the completed CQC comment cards from patients which told us what they thought about the practice. We received 52 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We noted several cards had mentioned specific GPs commenting on their kindness in times of stress and difficult health issues and how they had helped to overcome them. They reported that their quality of life had been improved by the strategies and interventions suggested by the GPs. Patients also commented that the GPs were particularly good when they had elderly or young children needing care and treatment. We also saw many comments regarding kind, helpful and efficient nursing and reception staff. Although almost all cards contained positive comments they included comments regarding areas which could be improved, such as the difficulty getting through on the telephone and the longer wait for an appointment to see a GP of choice. We also spoke with eight patients on the day of our inspection. All patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

The reception desk was open but once patients were checked in, the waiting areas were away from the reception desk which assisted in keeping patient information private.

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 practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey of 2014 showed 72% of practice respondents said the GP involved them in care decisions and 84% felt the GP was good at explaining treatment and results. A recent survey undertaken by the PPG in April 2015 which had received 128 responses showed that 82% of patients felt involved in care and treatment decisions. Patients we spoke with on the day of our inspection confirmed this view and also told us they felt listened to and supported by staff. They told us they felt they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

The practice had 'Carers Champions' who specifically assisted older patients who experienced difficulty in accessing the Choose and Book system and also assisted in organising transport if required.

Staff told us that translation services were available for patients who did not have English as a first language and we saw notices in the reception areas informing patents this service was available.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in the general quality of care provided. For example, 91% of respondents to the Patient Participant Group (PPG) survey said they were satisfied with the general quality of care provided by the practice. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded with care and concern when they needed help and provided support when required. We observed examples of this during our inspection and we saw evidence of several case studies which demonstrated specific examples of where the practice had made additional efforts to identify reasons for difficult patient behaviours which was having a negative impact on their health.

We noted that as a result, the examples we looked at had resulted in an improved quality of life for patients and had helped patients achieve better control over their health and adopt better health choices which in turn resulted in better health outcomes. Examples of actions from the practice included, intense and extensive contact with the patients, carers, relatives, the multi-disciplinary teams, specialist consultants, psychologist and the local council. This demonstrated a commitment to thorough holistic assessment and review until an improved outcome had been achieved. During our inspection, discussions with team members confirmed the practice's commitment, both from clinical and administrative staff. The practice had undertaken a survey for patient suffering with long term conditions which showed that 85% of patients felt that at their appointment they discussed what was most important for them in taking care of their own health.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. For example, Arthritis Care and Diabetes UK. The practice's computer system alerted GPs if a patient was also a carer. We saw written information available for carers in the reception area to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We noted that the practice had three GPs actively involved in the CCG, one was the locality chair person, and two other GPs led on end of life care and mental health. We saw minutes of meetings which demonstrated that the GPs attended and reported back to the practice any actions agreed to implement service improvements and manage delivery challenges to the local population. For example, in collaboration with two other providers in the CCG, the practice had implemented an ultrasound service which had reduced waiting times to within two weeks.

The practice had also implemented a phlebotomy service for their patients in response to suggestions for improvements from the PPG. We saw from the PPG report that the practice had been working with them to improve disabled access. The practice was successful in securing funds to install a lift, the installation of which was dependent on leases and funding timescales.

The practice had implemented a new telephone system to improve telephone access and had worked closely with the PPG to address initial problems with the system.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice provided services to a local accommodation for the homeless. The reception manager told us that they communicated with the manager of the accommodation to keep up to date with patients arriving and leaving. They also had good communication with learning disability homes and provided extended appointments for those patients.

Longer appointments were also available for families who attended for travel vaccinations and those with long term conditions, complex needs and mobility difficulties and any other patients who may have required them.

The practice had access to translation services and we saw this was advertised to patients in the reception area. We saw records to show that the practice had provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

Whilst the practice was arranged over two floors, staff informed us that patients with mobility problems were seen on the ground floor. The practice had acknowledged that the premises was not ideal for patients with mobility difficulties but had identified this would improve with the installation of the lift and ramp.

We saw that the ground floor waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 7.15am to 7.30 pm on Mondays and from 8.15am to 6.30pm Tuesdays to Fridays. There were also appointments available alternate Saturday from 8.30 until 12.30 for both the GP and nurse.

Appointment were bookable by phone, online or by attending the practice. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients on the website and in the patient leaflet.

Home visits were made to local care homes when required and we saw where visits had been requested and these had been undertaken by the duty doctor.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. Four of the eight patients we spoke with during our inspection told us they had called for

Good

Are services responsive to people's needs?

(for example, to feedback?)

an appointment that morning. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice's extended opening hours on was particularly useful to patients with work commitments and for families with children. This was confirmed by patients we spoke with on the day of inspection.

Listening and learning from concerns and complaints

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

Information was available to help patients understand the complaints system, for example there were leaflets and posters in the waiting areas and information on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at complaints received in the last 12 months and found they had been satisfactorily handled. They had been dealt with in a timely way with openness and transparency.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and noted that the telephone system was a theme that had been identified which the practice had addressed. We saw minutes from the weekly practice meetings which showed that the annual review of complaints had been shared with staff.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Discussions with staff demonstrated that they were all aware and committed to the vision and practice values. The practice vision and values included providing good access to equitable healthcare and continuity of care with good on-going relationships with patients. Staff all reported that the practice believed in patient centred care where the patients' needs came first with a need to go 'the extra mile' using a multi-disciplinary approach.

We spoke with ten members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We noted that the practice manager had organised an away day and saw that staff had discussed and agreed that the vision and values were still current.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at these policies and procedures and noted that they were appropriate, in date and had been reviewed annually.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP lead for safeguarding and lead GPs for specific clinical areas, such as learning disabilities and mental health . We spoke with ten members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it had a higher achievement than the rest of the CCG and national standards and had almost achieved the maximum total. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, we saw audits concerning prescribing, blood pressure monitoring and minor surgery.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the individual risk logs, which demonstrated identified risks and how they had been managed. We saw that risks were discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Clinical practice meetings were held weekly and included governance issues. We looked at minutes from meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly at allocated times. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures and they had commissioned the services of a consultancy to produce a staff handbook which was made available to all staff. We reviewed a number of policies in place to support staff which included equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

The practice manager told us they had promoted a 'no-blame' culture in the practice to encourage openness and learning from when things go wrong. Staff we spoke with confirmed this and felt supported to be open.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the patient participation group (PPG), patient surveys and complaints. We looked at the results of the survey carried out by the PPG and noted that the phlebotomy service was an area identified which the practice had pursued and implemented. The access for patients with mobility problems had also been an area which had been addressed and a positive outcome achieved.

Are services well-led?

Good

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

The practice had an active PPG which had increased by 18% from 2014. We spoke with the chair of the PPG who told us the practice worked well with them and demonstrated commitment to the patient views. They told us the PPG had 286 members who were communicated to online with a steering group of 40 patients of whom 12-18 attended meetings at different times. The PPG included representatives from various population groups. They had carried out a survey prior to our inspection as well as an annual survey. We looked at the analysis of the last patient survey, which was considered in conjunction with the PPG survey and noted that the practice had addressed the feedback from patients. The results and actions agreed from these surveys were available on the practice website. There was a specific GP allocated to attend the PPG meetings along with the practice manager. The PPG provided a monthly newsletter which was available to all patients and paid for by the practice to inform patients of the latest developments in services available at the practice.

The practice had gathered feedback from staff generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff we spoke with told us the practice was supportive of training and development and they felt involved and engaged in the practice to improve outcomes for patients. One GP trainee we spoke with told us they had been well supported throughout their time at the practice.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff training days where guest speakers and trainers attended.

The practice was a GP training practice and had three trainers and two associate trainers who worked to educate and support new doctors who wanted to become GPs. They had their own in-house schedule for training which all staff could attend. The practice manger also developed training for reception staff.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. We looked at several audit and minutes from meetings which confirmed this.