Westbank 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

Westbank Practice was inspected on Tuesday 4 November 2014. This was a comprehensive inspection.

Westbank Practice provides primary medical services to people living in the town of Exminster, Devon and the surrounding areas. The practice provides services to a homogeneous population group and is situated in a semi-rural location. The practice has a strong sense of its long history, local identity and strong links to the local community it supports. There has been a medical practice in Exminster since 1718. The practice team endeavours to create an environment where it is good to be a patient and good to work at the practice.

The Westbank Practice has a branch in Starcross. The Westbank Practice covers six villages and the local population is rapidly expanding. The practice supports an area of 60 square miles on the west bank of the river Exe. Housing development in this area means that the practice anticipates 1000 new patients now and a further 6000 planned in the next five years to the North of the practice. As a result the practice is currently taking measures to anticipate local medical infrastructure and development need. The practice is liaising with local council, neighbourhood development group, Teignbridge District Council and the planners, and involving the local councillors and MPs.

At the time of our inspection there were 8,102 patients registered at the practice with a team of six GP partners and two trainee GPs.

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

We rated this practice as good.

Our key findings were as follows:

Patient feedback about care and treatment was extremely positive. The practice had a patient centred culture. Practice staff were well trained and experienced. Staff provided compassionate care to their patients. External stakeholders were extremely positive about the practice.

Westbank Practice was very well organised, clean and tidy. The practice had well maintained facilities and was

Summary of findings

well equipped to treat patients. There were effective infection control procedures in place. Patients enjoyed relatively easy access to appointments at the practice. Patients had a named GP which improved their continuity of care.

The practice had a clear leadership structure in place and was well led. Systems were in place to monitor quality of care and to identify risk and manage emergencies.

Patient's needs were assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health.

Recruitment, pre-employment checks, induction and appraisal processes were robust. Staff had received appropriate training for their roles and additional training needs had been identified and planned.

Information about the practice provided evidence that the practice performed comparatively with all other practices within the clinical commissioning group (CCG) area.

Patients told us that they felt safe with the practice staff and confident in clinical decisions made. There were robust safeguarding procedures in place. Significant events, complaints and incidents were investigated. Improvements made following these events had been discussed and communicated with staff.

We saw several areas of outstanding practice including:

An active patient participation group (PPG) who had made significant contributions to the positive development and improvements to the practice. The practice PPG has been selected by the clinical commissioning group to create a video setting out how to set up and run a PPG, for their guidance and good governance to be shared with other PPGs in the region and nationally. The practice and the PPG had an outstanding level of mutual support and understanding.

The practice had undertaken to provide primary medical services to a local travelling community who had been refused treatment at other practices which were closer to their location. Their circumstances made them a difficult to reach and potentially vulnerable group. Staff at the practice had discussed and agreed to provide services to this group which showed an outstanding level of caring and responsiveness.

Clinical audits were often linked to medicines management in order to improve outcomes for patients. For example, an audit into disease modifying anti rheumatic drugs had led to further research being completed on this area. GPs at the practice had produced guidelines and a protocol to follow which was considered outstanding by the CCG.

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.

According to Quality Outcomes Framework (QOF) data and CQC information, the practice was safer than other similar practices and was improving over time. QOF is a voluntary scheme which provides financial incentives for practices to meet specific health targets. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There was a full staff meeting every month which included an open forum where GPs held a question and answer session on any topic with staff.

All opportunities for learning from incidents were maximised to support improvement. Information about safety was highly valued and also used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. Risk assessments included the facilities, equipment, infection control, fire and patient safety.

There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Discussions with practice staff and examination of the minutes of team meetings, audits and policies showed that systems were in place to ensure that all clinicians were not only up-to-date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.

We saw data that showed that the practice is performing highly when compared to neighbouring practices in the CCG. The practice is using innovative and proactive methods to improve patient outcomes and it links with other local providers to share best practice. For example, building alterations had been completed to improve patient confidentiality.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patient survey data showed 84% of patients rated the practice as excellent for almost all aspects of care. Feedback from patients about their care and treatment was extremely positive. We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and

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worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

The practice had an active Patient Participation Group which included an on-line group for patients unable to attend group meetings and forums in person. Staff felt supported by management at the practice and staff retention was high.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

We found the practice had initiated positive service improvements for their patients that were over and above their contractual obligations. For example, the provision of comfortable chairs in the waiting area as a result of patient feedback. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the PPG. Complaints had been responded to appropriately and within a reasonable timescale.

The practice had reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Are services well-led?

Good

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

The leadership team at the practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. The practice had a simple leadership structure which staff found easy to understand.

GPs had clear lead roles, for example in safeguarding, training, prescribing and appraisals. All staff reported their morale was high. Staff retention was high. Appropriate human resources policies were in place to support staff and also address performance and capability when required. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. We

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found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients, which included using new technology, and had an active patient participation group (PPG).

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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 population group of Older Patients over 75.

The practice maintained close links with a local day care centre and a community matron. Core group meetings were held to support this liaison. For example, the GPs attended gold standard framework monthly meetings, aimed at enabling generalist frontline staff to provide a gold standard of care for patients nearing the end of life. Evidence of this was shown in minutes of these meetings on the practice intranet.

The reception and administrative staff supported patients in this population group through the provision of a system known as 'choose and book' referrals. Administrative staff supported patients by helping them to use computer systems to select and book appointments at a time and on a day convenient to them.

The practice maintained liaison with the local Clinical Commissioning Group (CCG) regarding this population group, through a clinical forum group. The practice ensured that the practice website was accessible to older patients and facilitated links to local charities.

GPs at the practice ensured that end of life care plans also known as treatment escalation plans (TEP) forms were provided for all patients if requested, faxed to the out of hours service provider and the Ambulance Service so older patients at the end of their life received a streamlined service.

The practice provided hospital discharge summaries to keep GPs up to date with their patients and arrange follow up visits with them if required. The practice had a system in place to be notified if any of the patients were admitted to hospital in an emergency.

Medicine reviews were done continuously on every repeat prescription to help ensure patients in this population group were receiving the optimum levels and types of medicines.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions.

All patients with long term conditions formed part of the practice's core planning and recall system, so that patients with long term

conditions were continually reviewed and appropriate changes made to their treatment if required. All patients in this population group were seen by a GP at least once a year for a review or more frequently as appropriate.

Patient health questionnaires at the practice included questions on patient's weight, alcohol, cigarette intake and other health risk factors. These details were checked at review and entered on the practice computer system encounter screen and appropriate action taken where required.

The practice audited the results of reviews and records of patients in this population group. Between April 2013 and March 2014 the practice had completed reviews on 83% of patients with diabetes, 70.4% of patients with asthma and 93.5% of patients with chronic obstructive pulmonary disease (COPD).

Emergency processes were in place and Consultant referrals were made for patients in this group who had a sudden deterioration in health. When needed longer GP appointments and home visits were available. All patients identified with long term conditions had a named GP and structured annual reviews to check their health and medicine needs. For those patients 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 population group of families, children and young people.

An example of good practice was how the practice implemented a records alert system of regular cards from child health immunisations. This system triggers a request to invite the child and their parent or guardian in after three failed encounters, and contact is made with the health visitor to follow up. GP's told us they also opportunistically bring this up at consultations.

Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were judged to be at risk. The practice supported patients in this population group by monitoring accident and emergency department visits made. If the number of visits made met or exceeded three visits within a twelve month period, the GP requested an appointment with the patient and their parent or guardian.

The practice ensured that all childhood injuries or accidental ingestion of substances were discussed with the Health Visitor.

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Appointments were available outside of school hours and the premises was suitable for children and babies. The practice worked closely with the on-site midwife and health visitor to ensure clinics took place regularly and a tailored service was offered to patients.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working age people.

The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

The practice offered an online appointments booking service together with an online facility to order repeat prescriptions. GPs offered telephone consultations to patients especially those giving up smoking after surgery, or sooner if more urgent.

Health promotion leaflets relevant to issues affecting this population group were on display in the waiting room and on the visual display unit available for viewing in the patient waiting area. This information was discussed at reviews and opportunistically by GPs with patients.

The practice offered NHS Health Checks to patients aged 40-75. The practice had 3,868 patients in this group and had sent out 576 invites in the last 12 months. The capacity of the practice to offer health checks was then reached. Of these, 178 patients took up the offer of the health check. This represented 4.6% of the total number of patients in this age group. A GP showed us how patients who had risk factors for disease identified at the health check were followed-up within 10 days and were scheduled for further investigations.

Acupuncture, physiotherapy and complementary therapy were all services offered by the practice which had proved very popular with patients in this population group. The practice had also successfully referred many patients in this population to a gym and exercise facilities.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people living in vulnerable circumstances.

The practice had undertaken to provide primary medical services to a local travelling community who had been refused treatment at other practices which were closer to their location. Their

circumstances made them a difficult to reach and potentially vulnerable group. Staff at the practice had discussed and agreed to provide services to this group which showed an outstanding level of caring and responsiveness.

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with learning disabilities. The practice provided services to patients who lived on boats in the local area, and who had no traditional fixed abode.

The practice supported two nearby learning disability homes with their care plans and also provided a primary care link nurse for patients with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and ensured these patients had received a follow-up. This service included more frequent reviews if needed. The practice offered longer appointments for people with learning disabilities. The practice plan to use updated computer alerts on their computerised patient records, once the system is in place, to improve their monitoring and support for patients in this population group.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. For example they had sign-posted vulnerable patients to various support groups and third sector 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia).

Patients experiencing poor mental health had received 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. The practice had in place advance care planning for patients with dementia.

The practice offered the availability of longer appointments as appropriate. The practice had sign-posted patients experiencing poor mental health to various support groups and third sector

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organisations including national mental health charities and CAMHS (Child and adolescent mental health services) a mental health crisis team and memory services for older people. The practice provided a room for mental health support clinics at the practice.

The practice supported patient's mental well-being and access and the recovery and independent living with clear signposting to support groups. The practice maintained a carer's register and carer's support network for patients. Staff had received training on how to care for people with mental health needs and dementia. A dementia support worker had met with practice staff in July 2014 to discuss the needs of patients with dementia.

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection. We also spoke with two representatives of the patient representation group (PPG). The practice had provided patients with information about the Care Quality Commission (CQC) prior to the inspection. A CQC comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected 20 comment cards which contained extremely positive comments.

These comment cards recorded that patients thought that staff at the practice provided an excellent service. Patients reported that the practice was tidy and well organised. Patients expressed great confidence in all of the staff at the practice. 100% of patients were very satisfied with the care and treatment they received and with the cleanliness of the practice.

Written evidence was supported by our conversations with eight patients. The feedback from patients was extremely positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients said they were extremely satisfied and said they received excellent treatment. Patients told us that the GPs were courteous, polite and kind.

The majority of patients expressed satisfaction with the appointments system. Patients told us that appointments normally ran on time. The patient participation group (PPG) told us that the practice responded promptly and effectively to feedback and always listened to patient views.

Outstanding practice

A very active patient participation group (PPG) had made significant contributions to the positive development and improvements to the practice. The practice PPG had been selected by the Clinical Commissioning Group (CCG) to create a video setting out how to set up and run a PPG, for their guidance and good governance to be shared with other PPGs in the region and nationally. The practice and the PPG had an outstanding level of mutual support and understanding.

The practice had undertaken to provide primary medical services to a local travelling community who had been refused treatment at other practices which were closer to their location. Their circumstances made them a difficult to reach and potentially vulnerable group. Staff at the practice had discussed and agreed to provide services to this group which showed an outstanding level of caring and responsiveness.

Clinical audits were often linked to medicines management in order to improve outcomes for patients. For example, an audit into disease modifying anti rheumatic drugs had led to further research being completed on this area. GPs at the practice had produced guidelines and a protocol to follow which was considered outstanding by the CCG.

Westbank Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a second CQC Inspector, a GP specialist advisor, a practice nurse specialist adviser, a practice manager specialist advisor and an expert by experience. Experts by experience are people who have experience of using healthcare services.

Background to Westbank Practice

Westbank Practice was inspected on Tuesday 4 November 2014. This was a comprehensive inspection.

Westbank Practice provides primary medical services to people living in the town of Exminster, Devon and the surrounding areas. The practice provides services to a homogeneous population group and is situated in a semi-rural location. The practice has a strong sense of its long history, local identity and strong links to the local community it supports. There has been a medical practice in Exminster since 1718. As a result the practice team endeavours to create an environment where it is good to be a patient and good to work at the practice.

The Westbank Practice comprises two practices; Starcross Practice and The Westbank Practice. We visited Westbank Practice in Exminster during this inspection. The Westbank Practice covers six villages and the local population is rapidly expanding. The practice supports an area of 60 square miles on the west bank of the river Exe. The practice anticipates 1000 new patients now and a further 6000 planned in the next five years to the north of the practice. As a result the practice is currently requiring extraordinary measures to anticipate local medical infrastructure and development need. The practice is liaising with local council, neighbourhood development group, Teignbridge District Council and the planners, and involving the local councillors and MPs to meet this new demand.

At the time of our inspection there were 8,102 patients registered at the service with a team of six GP partners, two trainee GPs, a practice manager, four nurses, two phlebotomists and a further 16 administrative staff. GP partners hold managerial and financial responsibility for running the business.

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

The practice has a primary medical services contract with the NHS.

We visited Westbank Practice in Exminster during this inspection. We did not visit the Starcross practice.

Westbank Practice in Exminster is open Monday to Friday 8.30 am until 6 pm. In addition the practice offers late opening until 7.30 pm on a Monday evening.

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

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as

Detailed findings

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

This provider had not been inspected before and that was why we included them.

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

Before conducting our announced inspection of this practice, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, the local clinical commissioning group and local voluntary organisations.

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

We carried out our announced visit on Tuesday 04 November 2014. We spoke with eight patients, two patient representative group members at the practice during our inspection and collected 20 patient responses from our comments box which had been displayed in the waiting room.

We obtained information from and spoke with eight staff at the practice including the practice manager, four GPs, clerical staff, nurses and health care assistants. We observed how the practice was run and looked at the facilities and the information available to patients.

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

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

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

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, staff told us that incidents and the incident reporting procedure were regularly discussed at team meetings.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last four years. The practice had incident reports going back over the last 20 years. This showed the practice had managed these consistently over time and so could evidence 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. Records were kept of significant events that had occurred during the last 20 years and these were made available to us. A slot for significant events was on the practice meeting agenda and a dedicated meeting occurred monthly to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. For example, a patient had visited the practice suffering from an adverse reaction from a drug administered by a dentist. The patient had been referred to a local minor injury unit. On reflection the practice had implemented learning points which included the point that the patient could have been seen by the practice nurse. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who showed us the system she used to oversee these were managed and monitored. We tracked three incidents and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, guidance had been discussed with reception staff following the incident outlined in the paragraph above.

The practice maintained a significant events folder which was used for discussion in meetings. For example, in September 2014 GPs had discussed abnormal test results received after a particular medicine had been prescribed and taken by a patient. Action included changing the medicine dosage and retesting the patient with successful results. National patient safety alerts were disseminated by email and verbally to practice staff.

Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at team meetings to ensure all were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults.

Checks were made on patient's pathology forms to ensure safety. Systems were in place to ensure safety. For example, a GP carrying out these checks had spotted one patient's label on their pathology form did not show which practice the patient belonged to, and so the results could potentially have gone to the wrong practice.

Practice training records made available to us 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 regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible online and on hard copy.

The practice had dedicated GP's appointed as leads in safeguarding vulnerable adults and children who had been trained to level three safeguarding and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients

attended appointments; for example children subject to child protection plans were discussed with the health visitors and subject to regular case conferences to ensure their safety and wellbeing.

A chaperone policy was in place and displayed on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants. Both nursing teams and receptionist teams had undertaken chaperone training and understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. All staff had received a criminal records bureau check via the Disclosure Barring Service (DBS).

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence that annual audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Medicines Management

Controlled drugs were stored securely in a locked cabinet. The key for this was kept securely. Records for controlled drug storage and administration were kept securely in a treatment room.

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

All the medicines we checked were within their expiry dates. All medicines were checked monthly and a checklist documented this. Processes were in place to check medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of by an offsite pharmacist as required and in line with guidance.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. A protocol was in place. Patients could apply for a maximum of six repeat prescriptions, after which a GP consultation would be triggered

A patient had been discharged from a care home with the wrong medicine. This had been identified by a GP at the practice. The practice had a process in place to double check medicines which had been provided by local care homes for patients at the practice, and to check that care home staff understood the care which patients required.

Immunisations were administered by nurses using directions that had been produced in line with legal requirements and national guidance.

There was a secure fridge used for cold storage of vaccinations. The temperature of this unit was monitored via a visual display and recorded on a checklist. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

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 as these were tracked through the practice. During our inspection we found some blank prescription forms in an unoccupied treatment room. When we brought this to the attention of the practice manager it was rectified immediately. The practice understood their obligations to ensure material of this nature was always stored securely.

Cleanliness & Infection Control

The premises was clean and tidy. There were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice very clean and had no concerns about cleanliness or infection control.

The practice had a lead nurse for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and there after annual updates. We saw evidence the infection control lead nurse and the practice manager had together carried out an annual infection control audit every year for the past two years. Improvements identified for action were completed on time, for example hand washing guidance was on display in relevant areas for patients and staff, hand washing training had been completed for staff in January 2014. Practice meeting minutes showed the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan

and implement control of infection measures. For example, personal protective equipment including disposable gloves and aprons were available for staff to use and staff were able to describe how they would use these. There was also a policy for needle stick injury and guidance on display to support staff who experienced this.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). Monthly records throughout 2014 confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients. A legionella audit had been conducted in January 2014 which was planned to be repeated annually to review any changes.

Equipment

Staff at the practice told us they had enough modern equipment to enable them to carry out diagnostic examinations, assessments and treatments. Evidence showed that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date in March 2014. A schedule of testing was in place.

Staffing & Recruitment

Records 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 record bureau checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The practice manager told us they checked clinical staff's professional registrations on an annual basis to ensure these are maintained.

The GPs at the practice had a wide range of specialist skills including dermatology and diabetes. Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure they were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the efficient running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager had completed a staff needs analysis to ensure there were enough staff on duty to satisfy patient needs especially at peak times. For example, most patients rang the practice between 8.30am and 11am in the morning, the practice manager had identified this as the busiest time for the administrative team.

Monitoring Safety & Responding to Risk

Visitors to the practice signed in and were issued with a displayed pass containing their names and company. There was a visitor's code of conduct in place. Other systems to monitor safety included annual and monthly checks of the building, third party confidentiality agreements, fire plan and fire exit information on display at reception. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there were two identified health and safety representatives, one member of administration staff and the practice manager.

The main electrical system at the practice was tested every five years. Approved contractors' details were recorded and utilised to deal with any maintenance issues which arose. Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. For example, the practice manager had discussed at team meetings the practice business continuity plan. This set out how the practice could carry on operationally if one of their two sites was put out of action through flooding, fire or other emergency.

We saw records showing all staff had received training in administering first aid and basic life support to both adult and child patients in October 2014. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to return a patient's heart rhythm back to normal in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included

Good

Are services safe?

those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

An annual fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff had received fire training in October 2013 and that annual fire drills were undertaken.

[CJ1]Health care assistants cannot administer medicines against patient group directions only against patient specific directions. Please clarify and add to “must” if health care assistants are administering vaccines against PGDs

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs and other clinical staff we spoke with could outline the reasons for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings dated October 2014 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 evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found that staff completed thorough assessments of patients' needs and these were reviewed when appropriate. This was in line with NICE guidelines.

GPs told us they lead in specialist clinical areas such as diabetes, asthma, dermatology and said practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of diabetes.

We were shown the process the practice used to review patients recently discharged from hospital which required patients to be reviewed by their GP as required.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account negatively in this decision-making. There were five female and two male GPs at the practice, with a range of different ages.

Management, monitoring and improving outcomes for people

The practice enjoyed the services of a dedicated data controller who was responsible for data input, clinical review scheduling, alerts management and information technology. The information collated by the data controller was then used by the practice manager to support the practice to carry out audits and improve performance. For example, the data controller ensured that the capture and completion of Quality Outcomes Framework (QOF) was exemplary. QOF is a voluntary system which provides practices in England with financial incentives to achieve health targets.

The practice showed us eight clinical audits that had been undertaken in the last 12 months. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, a July 2014 audit had looked into the prescribing of a particular sleeping tablet. The audit had compared its effectiveness, cost and side effects with alternative medicines and made suitable recommendations to improve the patient experience.

Other examples of clinical audits included audits on diabetic medicines, to see whether their use complied with NICE guidelines. The audit found that in each case the guidelines had been complied with.

The GPs told us clinical audits were often linked to medicines management in order to improve outcomes for patients. For example, an audit into disease modifying anti rheumatic drugs had led to further research being completed on this area. GPs at the practice had produced guidelines and a protocol to follow which was considered outstanding by the Clinical Commissioning Group (CCG).

The team used clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon 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.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. A protocol was in place. Patients could apply for a maximum of six repeat prescriptions, after which a GP consultation would be triggered.

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 had outcomes comparable to other services in the area. For example, figures indicated that 95.6% of patients would recommend the practice to others. The practice scored 98.567 QOF points out of a possible 100. This was higher than the average across England.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

We reviewed staff training records and saw that staff were up to date with mandatory training on first aid, manual handling, fire safety and safeguarding. Staff had also had training within the last 12 months on such areas as information governance, data protection, chaperoning, and the Mental Capacity Act 2005.

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 every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example as the practice was a training practice, GPs who were in training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. Feedback from those trainees we spoke with was positive.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, those with extended roles such as the provision of a regular diabetes clinic were able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, and out of hour's providers, were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

We saw that the policy for actioning hospital communications was working effectively. If any results received following hospital referrals were complex or positive results then the patient's GP would contact them personally. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that none were missed.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients e.g. those with end of life care needs. These meetings were attended by community mental health nurses, district nurses, social services, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. GPs and nurses at the practice met regularly with midwives, health visitors and school nurses in the local area.

Information Sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. The practice shared treatment escalation plans (TEP) with the out of hours GP service when required.

For emergency patients, there was a practice policy of providing a printed copy of a summary record for the patient to take with them to A&E. This document could also be faxed from a secure fax to the hospital. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E and with the out of hours provider.

Consent to care and treatment

We found that staff had been trained within the last 12 months on the Mental Capacity Act 2005 and the Children's and Families Act 2014 and understood their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. The practice kept a register of all patients with learning disabilities. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it)

Good

Are services effective?

(for example, treatment is effective)

and had a section stating the patient's preferences for treatment and decisions. For example, all consent forms at the practice had been scanned into the electronic record system.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

The practice had not had an instance where restraint had been required in the last 3 years but staff were aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

The practice had met with the Public Health team from the Local Authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity. The practice also had an agreement with the local Healthwatch body to disseminate health promotion and prevention information.

New patients at the practice were invited to complete a comprehensive questionnaire about their health and medical history. This data was used to assess their needs and whether an initial consultation with a GP or nurse was required.

The practice offered NHS Health Checks to patients aged 40-75. The practice had 3,868 patients in this group and had sent out 576 invites in the last 12 months. The capacity of the practice to offer health checks was then reached. Of these, 178 patients took up the offer of the health check. This represented 4.6% of the total number of patients in this age group. A GP showed us how patients who had risk factors for disease identified at the health check were followed-up within 10 days and were scheduled for further investigations.

The practice offered smoking cessation clinics to support patients to stop smoking. GPs showed us evidence that 98.6% of patients who had stated they were smokers had been offered smoking cessation clinic support.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. There was a clear policy for following up non-attenders by the practice nursing team.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The practice regularly sought and reviewed patient feedback on this area. We looked at patient experience survey results completed over the last twelve months. This included information from the national patient survey, a survey of 322 patients undertaken by the practice's Patient Participation Group and patient satisfaction questionnaires undertaken by the practice. The evidence from all these sources showed patients were extremely satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the 2014 patient survey showed the practice was rated very highly for respect shown to patients. The practice was also well above average for its satisfaction scores on consultations with GPs and nurses with over 80% of practice respondents saying the GP gave them a warm greeting, listened to them and felt reassured by their visit.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 20 completed cards and all of these 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 also spoke with eight patients on the day of our inspection. All told us they were extremely 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 with expiry dates displayed were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass walls which helped keep patient information private.

Staff told us 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. This was reflected in team meetings which showed that learning points and customer service had been discussed.

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 surveys showed 84% of practice respondents said the GP involved them in care decisions and they felt the GP was good at explaining treatment and results.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

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 this area. For example, 84% of respondents to the patient survey said when it had been needed they were helped to access support services to help them manage their treatment and care. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Good

Are services caring?

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

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. Patients we spoke to who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to people'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. The practice used the adjusted clinical group tool which is a risk tool to help GPs detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease or condition.

There had been very little turnover of staff during the last five years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes on a specific day each week, by a named GP and to those patients who needed one.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, the practice now offered patients appointments with a GP of their choice by encouraging patients to visit both the Exminster and the nearby Starcross practice which together made up the Westbank practice. The practice had also increased nurse practitioner time at the practice for patients as a result of PPG feedback.

The practice had achieved and implemented the gold standards framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs. The practice worked closely with a local hospice which specialised in end of life care. The practice had ensured that patients who wished to remain at home had been able to and that patient's treatment escalation plans had been respected.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. The practice had undertaken to provide primary medical services to a local travelling community who had been refused treatment at other practices which were closer to their location. Their circumstances made them a difficult to reach and potentially vulnerable group. Staff at the practice had discussed and agreed upon this course of action which showed a level of caring and responsiveness.

The practice also provided services to patients who lived on boats in the local area without any traditional form of fixed abode. The lack of a permanent fixed home address had not disbarred these patients from registering with the practice and accessing primary medical services.

The practice had access to online and telephone translation services and GPs who spoke a range of languages other than English.

The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last twelve months and that equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

Appointments were available from 8.30 am to 5.30 pm on weekdays. Late opening was available on a Monday evening until 7.30 pm. The practice had a facility for urgent appointments to be made.

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 in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Written and verbal feedback from patients indicated that they were satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP 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 patient facing areas of the practice were situated entirely on the ground floor of the building. The practice

Good

Are services responsive to people's needs?

(for example, to feedback?)

had provided turning circles in the wide corridors of the practice for the use of patients with wheelchairs. This made movement around the practice easier and helped to maintain patients' independence.

The premises and services had been adapted to meet the needs of people with disabilities. Both double doors were automated at the entrance. A risk assessment of the building had been completed after the Disability Discrimination Act 2005. Wider doors for wheelchair users had been installed. There was space available in the waiting room for wheelchairs and in the patient's toilet.

The practice had homogeneous population of 97% whose shared native language was English. The practice could cater for other languages through translation services.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system, including posters and leaflets in the waiting area together with a visual display unit which included how to make a complaint should patients wish to do so. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at six complaints received in the last twelve months and found these had been satisfactorily handled and dealt with within a reasonable timescale. The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon. This included discussion at team meetings to share learning points.

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. We found details of the vision and practice values were part of the practice's business plan. These values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included the following aims:

- A strong commitment to fostering community links
- Work to the highest possible standard to improve health
- Passionate about patient-focused practice
- Recognise that in order to improve communication, attending meetings and sharing our clinical experience is essential
- To foster the health and personal growth of practice members

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at ten of these policies and procedures and most staff had completed a cover sheet to confirm they had read the policy and when. All ten policies and procedures we looked at had been reviewed annually and were up to date.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing above average compared with other practices across England. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice manager told us about a system they had to ensure every member of staff had completed their required reading of any updates. The online system for this was geared to send an alert to the practice manager if the new information had not been read.

The practice had completed a number of clinical audits, for example eight audits had been completed within the last twelve months on a wide range of medicine usage. This had resulted in an effective piece of research work and a protocol produced by GPs at the practice.

Every Friday the practice partner GPs and the practice manager held a clinical governance meeting. In addition on the first Monday of each month the practice partner GPs and the practice manager held a finance, staffing, safeguarding, referrals and any other business meeting. At both of these occasions we saw minutes to show that effective good governance was in place. For example, discussions about succession planning had taken place.

The practice manager also attended a monthly practice manager's forum in Exeter which also included the Local Area Team (LAT) and Clinical Commissioning Group (CCG). GPs from the practice also attended a regular clinical peer group forum. Nurses from the practice attended a clinical supervision course at another practice in order to share best practice.

Leadership, openness and transparency

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

We saw from minutes that team meetings were held regularly, at least monthly. 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. Team building events were held every six months.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of human resources policies including the induction programme which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, this included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Are services well-led?

Good

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

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

The practice had gathered feedback from patients through a patient experience survey, and a patient participation group survey within the last twelve months. We looked at the results of the patient experience survey and 84% of patients thought that all aspects of this practice were good, very good or excellent. The patient participation group survey had gathered feedback which showed patients wanted to see a GP of their choice and they perceived a lack of pre-booked appointments. We saw as a result of this the practice had encouraged patients to use both practices in order to visit a GP of their choice. The practice had also increased nurse practitioner time in response to feedback.

The practice manager showed us improvements which had been made to the waiting area which included glass walls to separate the area from the reception desk to improve privacy and confidentiality.

The practice had an active patient participation group (PPG) which has steadily increased in size. The PPG contained representatives from various population groups; including people with long term conditions, people over 75 years of age and people from the working population or recently retired. The PPG had carried out an annual survey and met every month. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

Staff showed us the practice whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

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

Two members of staff told us that they had asked for specific training to be given on diabetes. As a result the practice manager had arranged for a nurse with specialist skills in treating diabetes to visit the practice and deliver face to face training in this area to the staff. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had completed reviews of significant events and updated information and shared with staff via bi monthly staff meetings and to ensure the practice improved outcomes for patients. For example, the minutes of an October 2014 meeting showed a chronic kidney disease specialist had presented recent research and findings to the team. Staff told us they had found this informative and useful.