Cowplain Family Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Cowplain Family Practice on 28 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, and caring responsive and well-led services. It also was rated as good for providing services for the following population groups; older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable, people experiencing poor mental health (including people with dementia).

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 for.
- 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 a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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.

Summary of findings

- The practice also worked in collaboration with three other practices to provides medical cover to 10 step-up/down beds in a local care home to enable patients to be cared for in the community and avoid an unnecessary hospital admission.
- The practice had an easy read translation protocol on which patients were able to point to the national flag of their country to identify which language they spoke.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice had a very active patient participation group (PPG).
- The practice had a non-appointment service which meant that patients could note from the website and practice leaflet when their named GP was available and arrive at the practice and sit and wait for an appointment on the day. The practice ensured that their annual patient surveys included a review of the system to ensure this was still the preferred option for patients. The system was designed so that GPs were able to deal with all patient issues that occur on the day. Emergency appointments were also available for those patients which needed them.

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

Importantly the provider should

- Consider amending the adult safeguarding policy to include details of frequency of training for staff.
- Consider including confidentiality clauses within contracts of employment, although there is such a clause in the staff handbook which is contractually binding.

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 the National Institute for Health and Care Excellence and used it routinely. Patients' 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 for patients about the services available was easy to understand and accessible. 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. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Summary of findings

Patients told us it was easy to get an appointment with a named GP or a GP of choice, there was continuity of care and urgent appointments available on 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 the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good 

The practice is rated as good for being well-led. The practice had a clear vision with 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. High standards were promoted and owned by all practice staff and teams worked together 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. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice had a very active patient participation group (PPG).

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 relatively 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, health visitors and school nurses.

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 those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It 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). Practice records showed that 69 out of 72 patients on their register had received a health check and 24 out of 26 patients with a mental health diagnosis had an agreed care plan in place. 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 hosted a monthly memory clinic run by a specialist nurse and had a dementia drop in service.

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

Patients completed CQC comment cards to tell us what they thought about the practice. We received six 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 also spoke with 16 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

These findings were in line with results received from the National GP Patient Survey. For example, the national GP patient survey results for 2014/15 showed that 84.8% of patients described their overall experience of this practice as fairly good or very good.

Results from the National GP Patient Survey showed that 96.1% of patients find it easy to get through to this practice by phone, which was above the national average. A total of 93.4% of patients stated that they had confidence and trust in the last GP they saw or spoke to, which was comparable with the national average.

Areas for improvement

Action the service SHOULD take to improve

- Consider amending the adult safeguarding policy to include details of frequency of training for staff.
- Consider including confidentiality clauses within contracts of employment, although there is such a clause in the staff handbook which is contractually binding.

Cowplain Family Practice

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 practice manager specialist advisor.

Background to Cowplain Family Practice

Cowplain Family Practice is situated in purpose built premises in Cowplain, Hampshire. The practice has approximately 9000 patients registered with it. A total of 24% of practice population are aged 65 years or over. All patients have a named GP.

The practice consists of six GP partners, who provide a total of 40 weekly sessions. There are three male and three female GPs. The practice is a teaching practice and has medical students and trainee GPs. There are four practice nurses and a practice nurse co-ordinator and two healthcare assistants, one who is currently receiving training. The clinical team are supported by a practice manager and a deputy practice manager and a team of receptionist, administration staff and secretaries. The practice holds a General Medical Services contract.

The practice is open between 8am and 6.30pm on Mondays; 7.30am and 6.30pm on Tuesdays through to Fridays. The practice operates an open appointment system to see the GPs and nurses between 8.30am and 10.30am and 4pm until 5.30pm. Information on named GP availability was displayed in the practice and on the website. Pre bookable appointments were available between 7.30am and 8am. GPs shared the duty system on the days they worked. Late evening appointments were also available on alternate weeks.

When the practice is closed patients are advised to contact Hampshire Doctors on Call via the NHS 111 service.

The practice address is:

26-30 London Road,

Cowplain,

Waterlooville,

Hampshire,

PO8 8DL

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. Including local NHS England, Healthwatch and the clinical commissioning group. We carried out an announced visit on 28 July 2015 at Cowplain Family Practice. During our visit we spoke with a range of staff which included GPs, nurses and reception staff. We spoke with patients who used the service.

We asked the practice to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included practice policies and procedures and some audits. We also reviewed the practice website and looked at information posted on NHS Choices website.

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
- 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)

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, on occasions patients who attended the practice had suffered a stroke whilst waiting for their appointment. Reception staff requested and were given information on how to identify a stroke, so that they could summon help urgently if they suspected a patient was having a stroke.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. 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. We reviewed records of significant events that had occurred during the last two years and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held quarterly monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient, who became seriously unwell and required urgent medical assistance and that the practice had learned from this appropriately.

Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. GPs and staff told us that there was effective teamwork and staff would quickly share any incidents and discuss how they could be improved to prevent reoccurrence.

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

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 the adult and child protection policies and found they both covered what constitutes abuse and how to report and record concerns. We noted that the children's policy included details of frequency of training for staff and to which level it was required. However, there was no information within the adult policy on how often safeguarding training should be carried out. 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.

When locum GPs were used they were informed of safeguarding procedures and policies. When the nominated lead for safeguarding was not available, for example due to annual leave, then another GP would cover this role and this information was emailed to staff on a monthly basis, along with any safeguarding updates.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. One GP mentioned that when needed the clinical commissioning groups safeguarding team had been contacted with concerns identified and further advice sought if needed.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to

child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Usually nurses were used for chaperone duties and the practice ensured that a nurse was always present in the practice whilst GPs were seeing patients, in case a chaperone was needed. On occasion health care assistants acted as chaperones. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice had recently undertaken an audit of patients who had a chaperone to ensure this was recorded correctly. They found that the GPs had completed their section of the record, but the chaperone had not always completed their section. The practice had arranged chaperone training in August 2015 and planned to re-audit the records two months later to ensure that the policy was being followed correctly.

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines 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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw evidence that had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD.

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. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

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

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 and carry out staff training. 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 audits six monthly and an external professional had carried out a full audit in June 2015 and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

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 which can contaminate water systems in buildings).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

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 was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at five recruitment records and found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employment in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. If a member of staff did not have a DBS check, a risk assessment was in place demonstrating why one was not necessary for that member of staff's role. We noted that all staff had been issued with new contracts of employment; however, the contracts did not include a confidentiality clause.

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 that enough staff were 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 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 met planned staffing requirements. For example, one GP had to extend their absence and the mitigating actions had been put in place. The meeting minutes we reviewed showed risks were discussed at GP partners' meetings and within team meetings.

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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: the practice had a protocol for managing suspected heart attacks which was readily available and had clear directions of what actions to take. There was a nominated GP and nurse identified each day to deal with medical emergencies.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records 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 in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac

Good

Are services safe?

arrest, anaphylaxis and hypoglycaemia. The practice did not routinely hold stocks of controlled medicines for the treatment of acute pain. The reason for this was that there was a pharmacy situated in the same building had sufficient supplies of these medicines. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A 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 plan was last reviewed in December 2014.

The practice had carried out a fire risk assessment and this included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the 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. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their

records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. 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. The information staff collected was then collated by the practice manager and the administration team to support the practice to carry out clinical audits.

We reviewed a sample of clinical audits that had been undertaken in the last three years. Completed audits included one on the use of specific antibiotics. The initial cycle of the audits carried out in December 2013 showed that of the 10 patients who were prescribed these medicines, only one had received the antibiotics as a result of specific laboratory results, which identified that it was appropriate to use. GPs were provided with guidelines on prescribing of antibiotics and discussions were held in practice meetings about prescribing patterns. A re-audit in December 2014 showed 50 % reduction in these specific antibiotics being prescribed and there use was clinically appropriate. Other examples included audits to monitor inhaler usage for patients with asthma and use of bone sparing medicines (these provide a protective coating over bones) in patients who were at risk of osteoporosis.

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). The practice had commenced the medicines optimising programme in conjunction with the clinical commissioning group's guidance. This programme set out a list of medicines and alternatives which could be prescribed, to ensure efficient use of resources.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This

Good

Are services effective?

(for example, treatment is effective)

practice was not an outlier for any QOF (or other national) clinical targets, It achieved 99.2% of the total QOF target in 2014, which was above the national average of 94.2%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was similar to the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average
- Performance for mental health related and similar to the national average.

The team was making use of 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 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, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

The practice's prescribing rates were also similar to national figures There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had 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.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as patients living with dementia and those with learning disabilities. Structured annual reviews were also undertaken for people with long term conditions for example those with diabetes or heart failure.

The practice 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 courses such as annual basic life support. We noted a good skill mix among the doctors with two number having additional diplomas in sexual and reproductive medicine. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example training on travel vaccinations. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with. The practice maintained of a record of training undertaken and the date when it was next due. Caretaker had not received all training.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology and long term conditions. Those with extended roles were also able to demonstrate that they had appropriate training to fulfil these roles.

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. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing

Good

Are services effective?

(for example, treatment is effective)

on, reading and acting on any issues arising from these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw 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. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems and those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

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 in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

One GP gave us an example of how they involved patients in making decisions, they showed us examples of clinical records which confirmed this. We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. Training in the Mental Capacity Act 2005 had been given by the clinical commissioning group in conjunction with the county council. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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. These 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. For example figures from 2014/15 showed that 16 checks were carried out on 23 patients with learning disabilities. These patients were given a copy of their care plans.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 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, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve

Good

Are services effective?

(for example, treatment is effective)

mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 79.94%, which was at the national average of 81.88%. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 82.87%, and at risk groups 61.39%. These were slightly above to national averages.

Childhood immunisation rates for the vaccinations given to under twos ranged from 79.1% to 98.8% and five year olds from 92.3% to 100%. These were comparable to CCG averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey January 2015, a survey of 319 patients undertaken by the practice's patient participation group (PPG). (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also similar for its satisfaction scores on consultations with GPs and nurses. For example:

- 87.5% said the GP was good at listening to them compared to the CCG average of 90.1% and national average of 88.6%.
- 87.1% said the GP gave them enough time compared to the CCG average of 89.3% and national average of 86.8%.
- 93.4% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95.3%

Patients completed CQC comment cards to tell us what they thought about the practice. We received six 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. One comment was less positive but there were no common themes to these. We also spoke with 16 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk. Satisfaction scores showed 86.5% of patients found the receptionists at the practice helpful compared to the CCG average of 89.7% and national average of 86.9%.

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 similar or below the comparable local and national scores. . For example:

- 86.1% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88.4% and national average of 86.3%.
- 80.8% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 81.5%.

Patients we spoke with 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.

The practice showed us records related to those patients who had an admission avoidance plan. In total 145 patients had these plans and 129 of these patients were aged 65 and over. All plans had been agreed with patients and or their carer and reviewed regularly or after each hospital admission or A & E attendance.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated below local and national scores in this area. For example:

- 83.1% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88.9% and national average of 85.1%.
- 85.3% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90.4%.

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 compassionately when they needed help and provided support when required.

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. 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 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 and/or by giving them advice on how to find a support service. Patients we spoke with 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

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 practice had arranged for a practice nurse from another practice to cover their practice nurse's maternity leave to provide a service for patients with diabetes. The practice also worked closely with local practices and were in the process of completing a Vanguard bid to streamline services in the area and meet patients' needs effectively. These initiatives had been shared with patients and practice staff.

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 saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example to reduce waiting times at reception a self-check in screen was installed and members of the PPG group assisted patients to use this facility. A review of the system in March 2015 showed that there had been a reduction in patients needing to queue when there were several clinics operating. The practice also worked in collaboration with three other practices to provides medical cover to 10 step-up/down beds in a local care home to enable patients to be cared for in the community and avoid an unnecessary hospital admission.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. The practice had an easy read translation protocol on which patients were able to point to the national flag of their country to identify which language they spoke.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice 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 and that equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

The practice had a non-appointment service which meant that patients could note for the practice website or leaflet, when their named GP was available and arrive at the practice and sit and wait for an appointment on the day. The patients and practice referred to this system as a 'non-appointment' appointment system. The service worked well for the majority of patients and had been covered by a local news team early in 2015 as a positive way to manage appointments. The practice ensured that their annual patient surveys included a review of the system to ensure this was still the preferred option for patients. The system was designed so that GPs were able to deal with all patient issues that occur on the day. Emergency appointments were also available for those patients which needed them.

The practice telephone lines were open from 8am until 6.30am. Patients were also able to book appointments on line and order repeat prescriptions.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The GPs were available from 8.30am - 10.30am and from 4.00pm - 5.30pm Monday to Friday. The nurses were available from 8.30am - 10.30am and from 4.00pm - 6.00pm Monday to Friday. Early morning pre-bookable appointments were available with GPs and nurses from 7.30am - 8.00am Tuesday to Friday as well as late evening appointments on alternate Wednesdays with a female GP. Practice nurses operated an open appointment system but had booked appointments available for heart disease, respiratory disease, diabetes, travel, cytology, ECGs and leg ulcer dressings. Medical and postnatal checks were by appointment only.

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. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were available if needed.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 75.9% were satisfied with the practice's opening hours compared to the CCG average of 77.1% and national average of 75.7%.
- 86.6% described their experience of making an appointment as good compared to the CCG average of 79.8% and national average of 73.8%.
- 53.2% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 57.6% and national average of 57.8%.
- 96.1% said they could get through easily to the practice by phone compared to the CCG average of 84.3% and national average of 74.4%.

Patients we spoke with and comments cards we received showed that there was a high level of satisfaction with the appointment system. Comments on the NHS Choices website also aligned with these views. A total of 15 members of the PPG met with us on the day of inspection and all were positive about the appointment system and commented that GPs and nurses were proactive in encouraging patients to manage their conditions.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system on posters and in a summary leaflet, as well as 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 the seven complaints received in the last 12 months and found these were handled in a timely way and the practice were open and transparent when dealing with the complaint. A GP gave an example of a complaint which had been escalated to the General Medical Council (GMC) related to a potential delayed referral. The GMC considered the practice had acted appropriately and in a timely manner. The GP said that all the team had learnt from the experience and supported each other and as a result of the complaint the practice lowered their threshold for making referrals and some staff attended refresher courses to ensure patients would receive the best possible care. On the day of our inspection we noted that there were shortfalls with the system for requesting a change to a patients usual GP. The form did not include space for patients to request a male or female GP, this was immediately rectified and patients who had wished to change their GP were informed.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

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 strategy. We saw evidence the strategy and business plan were regularly reviewed by the practice and also saw the practice values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included offering continuity of care and maintaining high levels of patient satisfaction.

We spoke with nine members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them. We looked at minutes of the practice away day held annually 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 a sample of these policies and procedures and staff had completed a cover sheet to confirm that they had read the policy and when. All of the policies and procedures we looked at had been reviewed at least every two years and were up to date. Staff told us that they were emailed once a month to be informed of changes to policies and procedures.

We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

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 one of the partners was the lead for safeguarding. We spoke with nine 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. All of the six GPs also had involvement with the wider health community. For example, they worked in the out of hours and urgent care services, one GP was involved in commissioning services at a national level and the practice manager was one of six practice managers in the local area who provided support and mentoring for new practice managers.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice used an external data quality assessment to ensure disease registers were maintained and up to date.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented when needed. The practice monitored risks on a monthly basis to identify any areas that needed addressing.

The practice held regularly meetings which included clinician only meetings, multi-disciplinary meetings, nurses meetings and whole practice meetings. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

The practice had a clear leadership structure in place and staff held roles such as lead nurse and reception

Are services well-led?

Good

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

coordinator. This assisted in enabling communication across all teams. For example the reception coordinator attended the weekly practice meeting in order to be kept informed of changes and discuss any impact these might have on the reception team. Areas discussed at the practice meeting included premises, finances, staffing and significant events. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. The locum GP and GP registrar also said that the culture of the practice was open and staff were friendly and helpful and systems worked well. For example, administrative tasks were managed in a timely manner.

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

All GPs, including a locum GP we spoke with commented on the ethos of team working, good communication and leadership. All staff we spoke with considered that the leadership team was effective and they had a clear steer on what was expected.

We also noted that team away days and social events were held every regularly. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. The PPG had carried out annual surveys and met every quarter. 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. We spoke with 15 members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also gathered feedback from staff through an annual staff survey, which included using a value wheel to identify the strengths and areas which required improvement. The value wheel was displayed in the reception area. Staff were asked about three positive aspects of working at the practice and three areas where they considered improvements could be made. For example, one area identified was more structured training for new staff and feedback when a concern was raised. We saw action plans which showed how the practice was working to improve these areas. Positive areas included team working, variety of work and a pleasant building to work in that was well equipped.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

All staff we spoke with and records confirmed that the practice encouraged training and enabled staff to develop in their roles. Staff we spoke with considered that there was a good skill mix and training was always facilitated. The staff said this helped them to be effective and responsive to patient needs and assisted with staff retention. One health care assistant had commenced training to become a nurse and hoped to return to the practice to work when qualified. Another member of staff who worked on reception was also training to become a health care assistant.

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.

The practice was a GP training practice and facilitated up to two GP trainees at a time. The practice also linked with a local university to offer placements for medical students. GP trainees were supported by mentors and had longer appointment times allocated.

Are services well-led?

Good

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

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients.