Trent Meadows Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 2 October 2014 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains. We found the practice provided good care to older people, people with long term conditions, families, children and young people, working age people, people in vulnerable groups and people experiencing poor mental health.

Our key findings were:

- Patients were protected from the risk of abuse and avoidable harm. There were robust systems in place for safeguarding adults and children. Performance was consistent over time and there were effective arrangements in place for reporting safety incidents and learning from key safety risks.
- Patients received care and treatment which achieved good outcomes, promoted a good quality of life and was based on the best available evidence
- Staff were caring and treated patients with dignity and respect. Patients told us that staff were compassionate and kind. They said that GPs were good at listening to them and involving them in decisions about their care and treatment
- Services were organised to meet the diverse needs of the patients. The practice was aware that improvements were needed to the appointments system for non urgent appointments and was regularly monitoring how it worked. There was evidence that new initiatives were being trialled to address this
- The leadership, management and governance supported learning and innovation and promoted an open and fair culture. We saw that processes in place provided assurance that high quality care was being delivered

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

The provider should:

- Develop staff knowledge of the Mental Capacity Act 2005 in relation to their roles

Summary of findings

- Develop ways to improve support for bereaved patients

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learnt 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 effective. Our findings at inspection showed systems were in place to ensure that all clinicians were up-to-date with both the National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence that confirmed that these guidelines influenced and improved practice and outcomes for their patients. We saw data that showed that the practice was performing highly or on target when compared to neighbouring practices in the Clinical Commissioning Group (CCG). The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Good

The practice is rated as good for caring. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care. They worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patients' choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice 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 were identified. Patients reported good access to the practice for urgent appointments and a named doctor for continuity of care, with urgent appointments available the same day. Actions to improve the service for non-urgent appointments were seen to be in place. The practice had good facilities and was well equipped to treat patients and meet

Summary of findings

their needs. There was an accessible complaints system and evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the primary care needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice had already exceeded its 2014 and 2015 target for identifying patients with dementia at the time of the inspection.

The practice was responsive to the needs of older people, including offering home visits and telephone consultations for those with enhanced needs and home visits.

Staff were knowledgeable about the health needs of older people who used the service. The practice worked closely with two care homes to provide effective care to the patients who lived there. The practice took a proactive approach to respond quickly to their treatment needs in order to prevent hospital admission.

Influenza and shingles vaccinations were offered to older people according to national guidance. The practice provided support for carers and had developed a carer's register working with the local carer's association.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check 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.

The lead GP for diabetes care and the nurse practitioner offered a community diabetic service. The practice used the 'DESMOND' programme (Diabetes Education and Self Management for Ongoing and Newly Diagnosed) to promote self empowerment with patients with diabetes.

The practice used the Flo hypertension (high blood pressure) monitoring system which enabled relevant patients to record their own blood pressure readings. Time was given to each patient to

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explain how to use the system. A blood pressure monitoring device was given to them on loan by the practice. Once the patient texted their results to the Flo system, the results were analysed and the patient was invited in for an appointment if necessary. This reduced the number of times that the patient had to visit the practice and enabled the GP to maintain on-going monitoring of the patient's hypertension. The practice had acknowledged the mental health issues for patients with a long term condition and had actively signposted them to mental health support agencies. The practice was also proactive in signposting patients to organisations who could provide benefits support and equipment or accommodation.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals.

There were flexible immunisation appointment times at the practice as there was no fixed clinic. This enabled mothers to make appointments outside of 'school run' times. The premises were suitable for children and babies and there was a baby changing facility at the practice.

We were provided with examples of strong joint working with midwives and health visitors. The practice staff notified the health visitor immediately of all under five year olds who were newly registered so that the children could receive a prompt health check. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

The practice had a very low pregnancy rate, 0.49%, in the age of 15 to 17 years of age in their population compared to 2.7% in England. Staff told us that they had excellent relationships with their young patients and having known them for years, patients felt comfortable to discuss family planning issues with their doctor or nurse.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the working-age group and those recently retired (including 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 to ensure these were accessible, flexible and offered continuity of care. The practice

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offered a range of appointments; same day, telephone consultations and sit and wait. There were no set clinic times at the practice and the flexibility of this system enabled patients to attend for two reviews at the same appointment. For example for diabetes and asthma reviews. The practice had also extended opening hours once a week which was useful to patients with work commitments.

The practice offered a full range of health promotion and screening which reflected the needs of this age group including cervical smears and chlamydia testing. The practice also worked closely with the QUIT (smoking cessation) team at the Clinical Commissioning Group (CCG). This had proved to be extremely successful as the practice had achieved the highest percentage of patients who had given up smoking in East Staffordshire for two years running.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for patients living in vulnerable circumstances. The practice enabled patients to easily register with the practice including those of 'no fixed abode'.

The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice carried out annual health checks for patients with a learning disability and offered longer appointments for them.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice 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.

Decisions about care planning for end of life patients were documented in a shared care record available to all health professionals involved with the patient. A copy of the care plan was located in the patient's home. The practice had introduced an end of life drug box which was kept in the patient's home to be readily available when required.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the group of people experiencing poor mental health (including people with dementia). Patients who experienced poor mental health received an annual physical health check. We found that the practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia.

Summary of findings

One of the senior GPs at the practice had extensive experience in psychogeriatrics (a branch of psychiatry concerned with behavioural and emotional disorders among the elderly), drugs and alcohol. The practice had already exceeded its 2014 and 2015 target for identifying patients with dementia at the time of the inspection.

The practice sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND and SANE which offered support for those with a mental illness. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs.

One of the senior partners at the practice gave an example about a patient with mental health needs who attended the practice without an appointment and how they ensured the needs of the patient were met. It was clear that staff understood the needs of their patients and were flexible to enable vulnerable patients access the service.

Summary of findings

What people who use the service say

We spoke with 14 patients on the day of the inspection. All of them were very complimentary about the services provided at the practice. They said that the GPs and staff were very good. They told us that all the staff were kind and respectful. There were seven patients who told us that they had difficulty getting a non urgent appointment, however they received good care and treatment when they eventually saw a GP. Three patients said that they did not see the GP that they wanted to see. All of the patients told us that there was no problem at all getting an urgent appointment to see or speak with a GP.

We spoke with the chair of the Patient Participation Group (PPG). PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care for patients. They told us that they felt well supported by the patient liaison officer and the GPs who attended the meetings. We reviewed the 17 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. There were 14 comment cards which contained extremely positive feedback about the service provided by the practice. Patients told us that all staff were respectful and treated them with dignity, including reception staff. There were seven comments about the lack of availability of non urgent appointments and two negative comments made about unhelpful staff.

The chair of the PPG told us that there were plans for an online appointment booking system to be available to patients over the next few months. They were aware that some patients had difficulty getting non urgent appointments. They told us that the practice was trying to improve this situation and had introduced a number of initiatives including 'sit and wait' clinics. We were shown the minutes of the last PPG meeting. This identified that one of the PPG members had recently spent some time in Trent Meadows Medical Practice to observe the reception/appointments service. We were told that feedback about this experience would be shared at the next PPG meeting.

We looked at the national GP Patient Survey published in December 2013 which found that 78.5% of patients rated Trent Meadows Medical Practice as good or very good. This was below the Clinical Commissioning Group's (CCG) regional average and based on 125 responses. We were provided with a copy of the results of an annual survey carried out by the PPG. Questionnaires were given out to patients and put on the practice website. We saw that the aim of the questionnaire was to frame questions geared to the concerns identified by patients. There were 459 responses from patients. Analysis of the data showed that the main issues for patients were seen to be: access to a GP, waiting times in surgery and choice of GP. We saw that an action plan was in place which detailed the steps to address these issues.

Areas for improvement

Action the service SHOULD take to improve

- Develop staff knowledge of the Mental Capacity Act 2005 in relation to their roles
- Develop ways to improve support for bereaved patients

Trent Meadows Medical 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 specialist advisor, a practice manager specialist advisor and an expert by experience who had personal experience of using primary medical services.

Background to Trent Meadows Medical Practice

Trent Meadows is a general practice located in Burton-on-Trent in the East Midlands. There is a second branch surgery, Stretton Medical Centre which was not visited as part of the inspection. Trent Meadows Medical Practice is a training practice for fully qualified doctors to gain experience and higher qualifications in general practice and family medicine.

The practice has six permanent GPs (five male and one female), two registrars ((qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine), a locum GP, a practice manager, a patient liaison officer, a nurse practitioner, three practice nurses and two healthcare assistants. There is a medical secretarial team, a reception team and administrative staff. There are in excess of 11,400 patients registered with the practice (as at 31 March 2014). The practice is open from 8.25am to 6.00pm Monday to Friday, although is available to offer medical services to patients from 8.00am. It also provides one late night clinic 6.30pm to 9.25pm alternating each week with Stretton Medical Centre.

The practice treats patients of all ages and provides a range of medical services. Trent Meadows Medical Practice has a large percentage of its practice population, 65% in the working age group.

The practice provides a number of services for example reviews for asthma, diabetes and epilepsy. It also offers child immunisations, contraception advice and travel health vaccines.

Trent Meadows Medical Practice does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed.

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 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.

Detailed findings

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before the inspection we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 2 October 2014. During our inspection we spoke with two GPs, a nurse practitioner, a practice nurse and the practice manager. We also spoke with the senior administrator, the patient liaison officer, a reception supervisor, two receptionists and the chair of the Patient Participation Group. We spoke with 14 patients who used the service about their experiences of the care they received. We talked with carers and/or family members and reviewed relevant documents. We reviewed 17 patient comment cards sharing their views and experiences of the practice.

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 and national patient safety alerts as well as comments and complaints received from patients. Staff told us how they were supported to raise any concerns they might have and were able to explain the process for reporting those concerns.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events and accidents. The practice kept records of significant events that had occurred during the last 12 months and these were made available to us. Significant events were discussed at the weekly partnership meeting agenda and actions were reviewed from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. 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.

National patient safety alerts received were checked by the nurse practitioner and disseminated by email to all practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They told us that some alerts were discussed at practice meetings to ensure all were aware of them and the action that needed to be taken.

Reliable safety systems and processes including safeguarding

The practice used a range of information to identify risks and improve patient safety. Practice training records showed that all staff had received relevant 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 for staff.

The practice had two GPs who were trained to level 3 (advanced) in safeguarding. One of these had been appointed as the lead for safeguarding vulnerable adults and children at the practice. The GP demonstrated a commitment to safeguarding patients and was very clear about their responsibility.

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.

A chaperone policy was in place and detailed in the practice information booklet for patients. Staff confirmed that details of the chaperone service were displayed in the consulting rooms. We were told that information on how to request this service was included in the range of information held on the television in the waiting area which patients could see whilst waiting for an appointment. We saw that chaperone training had been undertaken by all nursing staff and health care assistants who understood their responsibilities when acting as chaperones. Two patients we spoke with told us that they had been offered the opportunity to have a chaperone present when intimate or invasive treatment was required to be carried out by the doctor.

The practice had a policy for the safe recruitment of staff including guidelines about seeking references, proof of identity and checking qualifications and professional registration. We looked at three staff files and found the recruitment policy had been followed. We saw that checks on the professional registrations of clinical staff at the practice were carried out and that all health professionals at the practice were registered and fit to practice. The practice ensured that patients were cared for by appropriately qualified and trained staff.

The practice manager confirmed that Disclosure and Barring service (DBS) criminal checks were carried out for all clinical staff. Records we checked supported this. DBS criminal checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post. This ensured that patients were protected from the risks of unsafe care. We found that DBS criminal checks had not been obtained for receptionists and a risk assessment had not been

completed to identify why this decision had been reached. The practice manager informed us that a risk assessment for all receptionists would be put in place and regularly reviewed.

During the inspection, we found that there were other reliable systems and processes in place to keep patients safe which included the safe storage of prescription pads and confidential patient records.

Medicines Management

We saw that medicines were stored securely and were only accessible to authorised staff. 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.

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. There were no controlled drugs held at the practice. Emergency medicines for medical emergencies were available and all staff knew where they were stored. Vaccines were administered by nurses using directions that had been reviewed and approved in line with national guidance.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

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 and kept securely at all times.

Cleanliness & Infection Control

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

The practice had a lead for infection control and we saw that all clinical staff received infection control training and updates. We saw evidence that the lead had carried out regular audits and that any improvements identified for action were carried out. Nurse 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, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy.

Good hand hygiene principles were encouraged by the practice. Hand hygiene techniques signage was displayed in staff and patient toilets.

The practice had a policy for the management, testing and investigation of legionella (a bacteria found in the environment which can contaminate water systems in buildings). We saw records that 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.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us and we saw evidence that all equipment was tested and maintained regularly. We saw that the equipment was checked weekly to ensure it was in working order and fit for purpose. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

Staffing & Recruitment

Records we looked at contained evidence that appropriate checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records 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.

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 there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and

Good

Are services safe?

administrative staff to cover each other's annual leave. We saw that the practice was proactive in reviewing and amending its staffing skills and levels. Staff told us there was usually enough staff to maintain the smooth running of the practice and there was always enough staff on duty to ensure patients were kept safe.

Monitoring Safety & 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. Those relating to infection control, medicines management, staffing, dealing with emergencies and equipment are covered under the specific headings in this section of the report. 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.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). 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. Processes were 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.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This was seen to be reviewed regularly and covered all aspects of the service including IT, staffing etc. Key contact numbers were included and a paper copy of the plan was kept in the practice by the practice manager.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurses we spoke with told us how they followed evidence based practice. The practice had a GP who had been allocated lead responsibility for disseminating guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated and the implications for the practice's performance and patients were discussed. Whilst there was no formal policy for ensuring clinicians remained up-to-date, all the GPs interviewed were aware of their professional responsibilities to maintain their knowledge.

Patients had their needs assessed and care planned in accordance with best practice. The senior GP partner showed us data from the local Clinical Commissioning Group (CCG) which identified very good performance by the practice in relation to antibiotic prescribing. This was seen to be amongst the lowest prescribers in the area. The practice referred patients appropriately to secondary and other community care services. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practise was shared with all clinical staff.

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 in this decision-making.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included: asthma, prescribing of tramadol (pain reliever) and immunisations of diabetic patients. We saw evidence of improved outcomes for patients following the completion of these audits. Doctors in the surgery carried out minor surgical procedures in line with their registration and National Institute for Health and Care Excellence (NICE) guidelines. Clinical audits of minor surgery were completed bi monthly by the nurse practitioner. Checks were carried out each month for patients who had received minor surgery to monitor any post operative infections. We found that all staff were appropriately trained and kept up to date.

The practice routinely collected information about patients care and outcomes. It used the Quality and Outcomes Framework (QOF) which is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. This framework enabled the practice to assess its performance and to undertake regular clinical audits. QOF data (and other national data returns) showed that the practice performed well in comparison to local practices. For example, the targets for dementia diagnosis rates within the practice had already been met for 2014 and 2015. This practice was not an outlier for any QOF (or other national) clinical targets. The practice met all the minimum standards for QOF in diabetes/asthma/chronic obstructive pulmonary disease (COPD) and achieved 99% of all QOF targets last year. Furthermore, the practice participated in local benchmarking run by the CCG. This benchmarking showed that outcomes were comparable to other services in the area.

We saw that the practice reviewed its performance regularly and action was taken to address any areas that required improvement. One example of this was the need to reduce antipsychotic drug prescribing (one that can be used to help severe anxiety or depression) which we saw had been achieved.

Annual appraisal documents showed all clinical staff were engaged in the audit process, and we saw team meeting minutes including clinical audit results. Staff spoke positively about the culture in the practice around audit and quality improvement.

Effective staffing

The practice had an appropriate number of key staff including medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We found that the process of revalidation for GPs was on going and some had already been revalidated or had a date for revalidation. Revalidation is the process by which all registered doctors have to demonstrate to the General Medical Council (GMC) on a regular basis that they are fit to practise and their knowledge is up to date.

All staff undertook annual appraisals which set out their key objectives and identified their learning needs. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for

Good

Are services effective?

(for example, treatment is effective)

example immunisation training. As the practice was a training practice, GP registrars were offered extended appointments with patients to ensure sufficient time was given to each patient. Each registrar had access to a senior GP throughout the day for support. All trainees had a weekly tutorial with their named supervisor and feedback from the trainees in the National Trainees survey was positive.

Through the appraisal system there was a robust way of identifying poor performance and this was addressed by agreement with the practice manager / lead GP. The practice manager gave an example of poor performance and how this was managed. An agreed action plan was put in place which led to on-going improvements which have been maintained.

Practice nurses also had defined duties they were expected to perform and the practice paid for nurses and healthcare assistants to attend regional and national training to meet these requirements.

Working with colleagues and other services

We found that the practice worked effectively with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service 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.

The practice held multidisciplinary team meetings regularly to discuss the needs of complex patients e.g. quarterly meetings for those with end of life care needs. These meetings were attended by other professionals including palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of these meetings as a means of sharing important information.

Information Sharing

The practice had systems in place to provide staff with the information needed to offer effective care. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use.

This software enabled scanned paper communications, such as those from hospital to be saved in the system for future reference.

Consent to care and treatment

We found that one of the GPs and a nurse practitioner that we spoke with had an understanding of the Mental Capacity Act 2005 (MCA) and their duties in fulfilling it. We did not see any formal training had been completed by staff on the MCA or the deprivation of liberties guidance (DoLs). Staff we spoke with confirmed this. The nurse practitioner that we spoke with demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions and give consent through illness or disability.

The practice had a robust policy to help staff understand the purpose of a community 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) certificate. This DNACPR policy highlighted how patients should be supported to make their own decisions in relation to resuscitation and how these should be documented in the medical notes. A DNACPR should provide advice to medical professionals on what actions to take in an emergency and in accordance with the patient's wishes. One of the senior partners showed us a leaflet which had been developed to explain DNACPR for patients and relatives and provided information in an easy to read and user friendly format.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was obtained which included details of the relevant risks, benefits and complications of the procedure.

We saw that the practice had a consent policy and consent forms. The nurse practitioner that we spoke with told us that verbal consent was always recorded on the patient's clinical record. They confirmed that written consent was

Good

Are services effective?

(for example, treatment is effective)

always obtained for patients who needed minor surgery and from parents prior to immunisations given to their child. The nurse practitioner gave examples of the support that was provided for those people who lacked capacity to give written or verbal consent.

Health Promotion & Prevention

The practice helped their population to live healthier lives. It was practice policy to offer all new patients registering with the practice a health check with the health care assistant. The practice offered NHS Health Checks to all its patients aged 40-75. We saw that this was promoted on the practice website, in the information for patients on the television in the waiting area and in the practice leaflet. The nurse practitioner confirmed that any patients who had risk factors for disease identified at the health check were seen by a GP within days and scheduled for further investigations where necessary.

The practice offered a free kit for chlamydia screening to patients aged 18-25 which was another example of where the practice promoted good health and well being when each patient attended for family planning services.

We were informed that the practice was up-to-date with the implications of the Joint Strategic Needs Assessment**.** This is an assessment of the health and social care needs of the local population and we saw that the practice worked effectively with other services to provide holistic care. For example, the practice had identified the smoking status of all patients over the age of 16 and actively offered nurse led smoking cessation clinics to these patients. The practice worked closely with the QUIT team at the CCG. This had proved to be extremely successful as the practice had achieved the highest percentage of patients who had given up smoking in East Staffordshire for two years running.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all were offered an annual physical health check. We were informed that 38 people with a learning disability were on the register at the time of the inspection.

The practice's performance for cervical smear uptake was on target with those set by the CCG. Each year the practice carried out an audit of those patients who did not attend appointments and they were offered various reminders either by telephone or letter

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations (offered to all over the age of 65, those in at risk groups and pregnant women). The shingles vaccination was offered according to national guidance for older people. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

The practice held a register of all patients with a severe mental health problem. These patients received an annual physical health check by the practice. Staff confirmed that they worked closely with the local primary care mental health team to support patients who were experiencing poor mental health.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 459 patients undertaken by the practice's Patient Participation Group. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care for patients. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with dignity and respect.

The data from the national patient survey 2013 showed that over 90% of practice respondents (above the Clinical Commissioning Group's weighted average) said they had confidence and trust in the last GP and nurse they last saw or spoke with at Trent Meadow Medical Practice.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 17 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a very good service and staff were kind and helpful. They said staff treated them with dignity and respect. We also spoke with 14 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. Eight patients we spoke with said that staff were kind and compassionate. They also said there were difficulties getting an appointment but once they were seen, the service from the GP was very good or excellent.

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

All of the patients we spoke with told us that the clinical staff took time to explain their condition and treatment options to them. They said that they were provided with information to enable them to make informed choices and that they felt involved in decisions about their care.

The reception desk was located in a large open waiting area. Two patients told us that this could be difficult when they needed to discuss private information with staff when other patients could overhear. We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. We discussed patients' feedback with the practice manager who told us that they would arrange for a poster asking patients to give others privacy at the reception desk.

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.

Staff told us that people who lived in vulnerable circumstances or had drug or alcohol issues were able to access the practice without fear of stigma or prejudice. Staff said that patients were treated in a sensitive and sympathetic manner.

Care planning and involvement in decisions about care and treatment

The 2013 national patient survey information we reviewed showed some patients, 69%, felt that the clinical staff involved them in planning and making decisions about their care and treatment. Others, 84%, felt the GP was good at explaining treatment and results. Both these results were slightly below the weighted Clinical Commissioning Group's (CCG) regional average. Over 90% of patients who responded to the national survey said that they had confidence and trust in the last GP or nurse they saw or spoke to. The practice's own satisfaction survey did not include questions about patients' involvement in decisions about their care. Results from this survey showed that the key issues for patients were access, choice of GP and waiting times for appointments. The practice was seen to be taking steps to address these issues.

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 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 available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. We saw information was available for patients informing them about this service.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection and the comment cards we received demonstrated that staff at the practice responded compassionately when patients needed emotional help and support.

We saw that there were notices in the patients' waiting room, on the TV screen and patient website which signposted patients to a number of support groups and organisations, for example literature about the support services available for carers at the local carer's association.

Staff told us that a primary care mental health worker attended the practice one day per week and offered counselling for those who had been referred by the GP. Patients who had suffered a bereavement were referred to a local support group or other services depending upon their need. A patient we spoke with told us that they had recently lost a relative and the GP offered them a referral to a support service but they declined.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that the service was responsive to people's needs and had sustainable 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 NHS Local Area Team (LAT) 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 evidence where this had been discussed and actions agreed to implement service improvements such as prescribing specific medicines for patients.

There had been very little turnover of staff during the last three years which enabled good continuity of care and improved 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 doctor 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. All patients who needed to be seen urgently were offered same-day appointments or the opportunity to 'sit and wait'.

Staff told us that the practice used the Flo hypertension (high blood pressure) monitoring system which enabled relevant patients to record their own blood pressure readings. The health care assistant at the practice spent time with each patient explaining how to use the system. A blood pressure monitoring device was given to them on loan by the practice. Once the patient texted their results to the Flo system, the results were analysed and the patient was invited in for an appointment if necessary. This reduced the number of times that the patient had to visit the practice and enabled the GP to maintain on-going monitoring of the patient's hypertension.

The practice had an active patient participation group (PPG) to help it to engage with a cross-section of the practice population and obtain patient views. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care for patients. We spoke with the chair of the PPG who explained their role and how they worked with the practice. They told us that they felt very supported by the practice and the meetings were supported by one of the GPs and the patient liaison officer. They confirmed that they felt listened to and actions were taken by the practice in relation to any issues raised by the PPG.

The practice had achieved and implemented the gold standards framework for end of life care. They held a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients and their families care and support needs. Decisions about care planning for end of life patients were documented in a shared care record available to all health professionals involved with the patient. A copy of the care plan was located in the patient's home. The practice had introduced an end of life drug box which was also kept in the patient's home and available immediately when required.

The practice worked collaboratively with other agencies and regularly updated shared information to ensure good, timely communication of changes in care and treatment. Examples of this was in relation to the shared care plans of patients who were end of life.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Examples of this were: for those with a learning disability, patients with a mental health condition and carers. The practice proactively removed any barriers that some people faced in accessing or using the service. Staff we spoke with were knowledgeable about how to support patients who were homeless, travellers or temporary residents. For example the practice enabled people who were temporary resident in the area to register with the NHS by allowing them to use the practice address.

The practice had a register of patients who had a learning disability who were contacted for an annual review. We saw that there was a system for flagging vulnerability in individual records such as those people who were at the end of their life.

The practice population was 92% British or mixed British and 5% Asian and 3% eastern European. Staff confirmed that they used the telephone translation service if a patient did not speak English. The practice website had a facility to translate its home page into a large number of different languages at the click of a button. This enabled patients to understand the range of services available in their native

Good

Are services responsive to people's needs?

(for example, to feedback?)

language and how to access them and practice opening hours. We saw that reception staff booked an interpreter to support patients where English was their second language in order for them to explain their health concerns and understand the treatment proposed by the GP. Two of the GPs at the practice spoke another language in addition to English and a female GP was able to support patients who preferred to have a female doctor.

We saw that there was a facility for information to be received and sent by fax for patients who had a hearing impairment. This reduced any barriers to care and supported the equality and diverse needs of the patients. All staff had completed equality and diversity e-learning and the practice manager confirmed that they had recently attended an off site training session in this area. Staff told us that all patients received the same quality of service from them to ensure their needs were met without stigma or prejudice. We saw evidence of this during the inspection where staff demonstrated a caring and supportive approach towards a patient who was deaf.

Staff told us that that patients were treated in a sensitive and sympathetic manner. Patients we spoke with confirmed this. We were given an example where some patients with mental health problems repeatedly turned up without appointments. Staff confirmed that some of these patients were generally poor at attending regular appointments, and due to their health condition, the GPs always did their best to see them.

The premises and services were set out to meet the needs of people with disabilities. We saw that there was easy access to the practice and all the consulting rooms and treatment rooms were on the ground floor. There were easily accessible disabled toilets for patients and staff and a baby changing facility. For patients with a disability there were a number of facilities to support them such as a large font practice leaflet, clear signage and portable induction loops for patients who had a hearing impairment. The practice website informed patients with a disability that they were able to make appointments using the email system as well as the telephone and face to face access at reception.

Access to the service

The practice was open from 8.25am to 6.00pm Monday to Friday, although was available to offer medical services to patients from 8.00am. The practice held a late night clinic every week on alternate Tuesdays from 6.30pm to 9.25pm at each site. The practice offered both pre-bookable and same day appointments. Staff told us that patients were offered a telephone consultation with the GP if appropriate and said they would fit the patient in to be seen the same day if necessary. Home visits were also arranged for those patients who were unable to go to the practice. A follow up appointment system was also in place so that patients could book these following a consultation with the GP removing the need to telephone for an appointment at a later date.

Comprehensive information was available to patients about appointments on the practice website and in the practice booklet. This included details of the 'sit and wait' appointments facility, how to arrange urgent appointments and home visits. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of hour's service. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring of the out-of-hours service.

Patients were generally satisfied with the appointments system. Out of 14 patients we spoke with, nine patients said they could see a doctor on the same day or next day if they needed to. They also told us that they could see another doctor if there was a wait to see the doctor of their choice. However five patients said that non urgent appointments could take up to 10 days and appointment times often over-ran. A number of comments we 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. One patient told us how they needed an urgent appointment for their child. They had called in the morning and were fitted in to see a GP within a couple of hours.

The practice's extended opening hours on a Tuesday evening was particularly useful to patients with work commitments. This was confirmed by a patient who told us they brought their elderly parent to the practice when they finished work which was very helpful.

The senior GP partner at the practice gave an example about a patient with mental health needs who attended the practice without an appointment and how they ensured the needs of the patient were met. It was clear that staff understood the needs of their patients and were flexible to enable vulnerable patients access to the service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw evidence that the appointments system was frequently monitored to check how the system was working. We saw that action had been taken to try to improve the issues including the introduction of the 'sit and wait' service and an online appointments booking facility was due to be introduced in the near future.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was seen to be in line with recognised guidance and contractual obligations for GPs in England. The patient liaison officer at the practice was the designated responsible person who handled all complaints in the practice.

Accessible information was provided to help patients understand the complaints system with details about how to make a complaint in the practice booklet and in a complaints leaflet. Evidence seen from reviewing a range of feedback about the service, including complaint information and supporting operational policies for complaints and whistleblowing, showed the practice responded quickly to issues raised. The practice had appointed a patient liaison officer with specific responsibilities to support the patient participation group (PPG) and ensure patient complaints were progressed and resolved as far as possible. This demonstrated a proactive approach to listening and facilitating the voice of the patient. We saw that the practice had received a small number of complaints and these had been satisfactorily handled.

The practice also analysed complaints on an annual basis to ensure they could detect themes or trends and improve the service patients received as a result of feedback. We saw evidence of shared learning from complaints with staff and other stakeholders. One example of this was where following a complaint, a reminder was given to all administrative staff to ensure the correct codes on patients' notes were recorded. The patient liaison officer also gave an example where complaints were used to improve processes at the practice. Changes to the registration process for new patients at the practice had been carried out as a direct result of a complaint made by a patient. We also saw evidence where complaints were discussed at staff meetings to ensure all were able to learn and contribute to determining any improvement action that might be required.

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 vision to deliver high quality, person centred care for patients. In the practice leaflet we saw that the aim of the practice was: 'to provide all our patients with a friendly, professional service where they and their families can expect a prompt and understanding approach, complete confidence and assistance with their needs'. We saw this was also on the practice website. Staff told us that they felt strongly about working together as a team to provide positive outcomes for patients.

The management team at the practice were in the process of formalising their business plan and the practice manager showed us evidence of a training event that they had attended the previous week to support this. We saw that business meetings took place bimonthly and at that, forward planning was discussed.

We saw evidence where the practice worked together with other key partners who had a common focus on improving quality of care and people's experiences, for example fostering services.

The senior GP partner informed us that the practice staff supported the Nolan Principles. These are principles of good conduct for people in public office and include honesty, openness and integrity amongst others. The senior GP partner told us that they supported and promoted these principles by leadership and example. The practice was a training centre for GPs and we found that the ethos of promoting good practice for patients was embedded in the leadership and culture of the service. We saw that there was openness, honesty and transparency at a senior level in the practice. This was visible throughout the organisation and staff told us that they felt supported, valued and motivated. Staff we spoke with demonstrated their commitment to these principles and to providing a high standard of service for patients.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the senior management team were visible and accessible. There was evidence of strong team working. Records showed that regular meetings took place for all staff groups. The practice manager told us that they met with the GPs each week and information from those meetings was shared with staff. Staff confirmed that they felt able to contribute to meetings and raise any ideas for improvement or issues if necessary. They told us that the GPs, practice manager and other senior staff were very supportive.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via any computer within the practice. We looked at eight of these policies and procedures and found that staff had to sign to confirm that they had read and understood the policy which was monitored by the practice manager. We saw that all eight of the policies and procedures we looked at had been reviewed annually and were up to date.

We saw that the practice manager had regular meetings with the GPs and senior staff in the practice. There were other regular meetings which took place with administrative staff and the lead nurse held regular team meetings with the clinical staff. We looked at minutes from the last partner's meeting which contained updates from the nursing and administrative meetings. We saw that performance, quality and risks had been discussed.

The practice held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract, quality and performance was monitored using the Quality and Outcomes Framework (QOF). The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. We looked at the QOF data for this practice which showed it was performing in line with national standards scoring 99.6 out of a possible 100 points.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at bimonthly business meetings and action plans were produced to maintain or improve outcomes.

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 GP who was the lead for safeguarding. There was a rotating lead partner arrangement in place at the practice to promote learning

Are services well-led?

Good

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

and continuous professional development. We were told that two of the GPs at the practice were members of the Clinical Commissioning Group (CCG) and the Local Medical Committee (LMC).

We spoke with four 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.

Practice meetings were held every week and key information from these were shared with all staff. We saw minutes that showed other 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 to raise issues at team meetings and individually with their line manager.

We reviewed a number of human resource policies, for example, induction and recruitment policies which were in place to support staff. We were shown a copy of the 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.

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

The practice had an active patient participation group (PPG) which was supported by the patient liaison officer. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care for patients. The PPG met every month and one of the GPs at the practice attended most meetings. The PPG had carried out a number of surveys. The patient liaison officer showed us the analysis of the last patient survey which was carried out by the PPG. The results and actions agreed from this survey were available on the practice website. We saw that this was not a general satisfaction survey and had been designed to focus on the concerns identified by patients at that time. The results showed that patients continued to be satisfied with the consultations that they had and there were improvements from the previous year in relation to access to repeat prescriptions for example. The results identified that there were other issues for patients including appointments and access. We saw as a result of this the practice had introduced a 'sit and wait' appointments scheme and patients told us that they found this extremely useful.

One GP told us that a patient who had made an adverse comment on the NHS Choices website had been invited in to see the surgery working. This demonstrated an open and transparent culture where patients were listened to and comments taken seriously.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. We saw that the senior GP partner attended some of the nurse meetings. Minutes from this showed that the nurses could raise any issues which were actioned by the GP. 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.

The practice had a whistle blowing policy which was available to all staff and could be accessed electronically on any computer within the practice.

Management lead through learning & improvement

We looked at records which showed that a range of training was provided to staff at the practice. We saw evidence of a thorough induction training plan. Records showed that training was completed by all staff and uptodate. The nurse practitioner told us that the practice always supported them to access relevant training and had progressed from an enrolled nurse status to registered nurse and nurse prescriber with the help of the practice.

We looked at three staff files and saw that regular appraisals took place which included a training plan. Staff told us that the practice was very supportive of training and that in addition to the mandatory training they completed, they also had a variety of other relevant training. For example, we saw that three staff were due to receive medical terminology training. Staff confirmed that they had six to eight protected learning time sessions each year. Receptionists had also completed specific training courses for their role.

The practice was a GP training practice and we found that there was a supportive GP buddying system in place for GP registrars at the practice. This system provided the GP registrars with direct access to GP support each day. The GP registrars also had their own syndicate and attended a monthly forum for networking and to share experiences.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings to

Are services well-led?

Good

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

ensure the practice improved outcomes for patients. For example we saw evidence of a significant event discussed at one of the partnership meetings. Minutes of the meeting showed that the action required to prevent a reoccurrence of the event was to be raised at the next staff training day. Staff confirmed that this had been followed up and shared with staff at the training session.