St Johns Medical Centre

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 St John's Medical Centre on 8 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring responsive and well led services. It was also good for providing services for patients with learning disabilities.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice obtained feedback from patients in many different ways such as patient questionnaires, a suggestion box, the friends and family test and surveys undertaken by medical students. They were responsive to suggestions received.
- 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.

We saw four areas of outstanding practice:

Summary of findings

- The practice have introduced a system to monitor the quality of service around appointments, referral letters, scanning and telephone consults provided to the patients. It is positioned where it can be seen by all staff and is used as a staff 'self-monitoring' tool to encourage improvement, specifically in any areas of concern creating better access for patients.
- One of the GPs with an interest in learning disabilities had made significant positive impacts on the lives of a specific group of patients. The GP had taken the time to explore their social environment which impacted negatively on their mental and physical conditions. The GP worked with other health and social care professionals and individuals outside of clinical environments to help integrate these patients into society and improve their quality of life.
- The GPs met every lunch time to discuss patients they had seen since the previous day, provide peer support and share good practice. The discussions included challenge and changes in practice were made where they were felt appropriate.
- 'Hot clinics' had been introduced for children under the age of 5 years and these were available both in the mornings and after school hours.

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

- Although we saw evidence of full cycle clinical audits, the practice were not proactive in completing these.
- Although an advanced nursing practitioner had recently been employed, additional nursing hours were required to meet the needs of the practice and its patients.
- We established that the health care assistant (HCA) was responsible for most of the checks relating to medicines management, equipment, emergency drugs and cold chain. There was no written policy in place to outline what checks were required and who was responsible for those checks in the absence of the HCA.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) 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 to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

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

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needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

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

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Immunisation rates were relatively high for all standard childhood immunisations. Hot clinics' had been introduced for children under the age of 5 years and these were available both in the mornings and after school hours. 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

Outstanding 

The practice is rated as outstanding for the care of patients with a learning disability. One of the GPs with an interest in learning disabilities had made significant positive impacts on the lives of a specific group of patients. The GP had taken the time to explore their social environment which impacted negatively on their mental and physical conditions. The GP worked with other health and social care professionals and individuals outside of clinical environments to help integrate these patients into society and improve their quality of life.

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). 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 care planning and for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations such as MIND and SANE. 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 were knowledgeable about how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We received only three completed Care Quality Commission (CQC) comment cards were all positive. However we also reviewed Friends and Family responses, feedback from patient suggestions and responses from thank you cards and comments of appreciation. Patients spoke positively about the practice, and the care and treatment they received. Their descriptions of staff included helpful, friendly, thorough and kind. Patients told us staff understood and they were treated with dignity, compassion and respect. They told us staff listened to them and took time to discuss and explain treatment options. Patients felt involved in planning their care and treatment.

Most patients expressed satisfaction about the ease with which they could get an appointment. They told us urgent appointments were always available and they were sure they would be 'slotted in' even if all appointments were taken should they need it. Several patients commented on the environment saying it felt safe and hygienic.

We looked at the results of the 2014/15 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England.

These are the three results for the practice that are the highest compared to the Clinical Commissioning Group CCG average :

- 90% of respondents say the last GP they saw or spoke to was good at treating them with care and concern compared with the CCG (regional) average of 83%.
- 82% of respondents were satisfied with the surgery's opening hours compared with the CCG (regional) average of 77%.
- 93% of respondents described their overall experience of this surgery as good compared with the CCG (regional) average of 89%.

Areas for improvement

Action the service SHOULD take to improve

- Although we saw evidence of full cycle clinical audits, the practice were not proactive in completing these.
- Although an advanced nursing practitioner had recently been employed, additional nursing hours were required to meet the needs of the practice and its patients.
- We established that the health care assistant (HCA) was responsible for most of the checks relating to medicines management, equipment, emergency drugs and cold chain. There was no written policy in place to outline what checks were required and who was responsible for those checks in the absence of the HCA.

Outstanding practice

- The practice have introduced a system to monitor the quality of service around appointments, referral letters, scanning and telephone consults provided to the patients. It is positioned where it can be seen by all staff and is used as a staff 'self-monitoring' tool to encourage improvement, specifically in any areas of concern.
- One of the GPs with an interest in learning disabilities had made significant positive impacts on the lives of a specific group of patients. The GP had taken the time to explore their social environment which impacted negatively on their mental and physical conditions. The GP worked with other health and social care professionals and individuals outside of clinical environments to help integrate these patients into society and improve their quality of life.

Summary of findings

- The GPs met every lunch time to discuss patients they had seen since the previous day, provide peer support and share good practice.
- 'Hot clinics' had been introduced for children under the age of 5 years and these were available both in the mornings and after school hours.

St Johns Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, a GP adviser, a nurse specialist and an expert by experience. An expert by experience is someone who has used health and social care services.

Background to St Johns Medical Centre

The practice delivers primary care under a General Medical Services Contract between themselves and NHS England. As part of Trafford Clinical Commissioning Group (CCG) they are responsible for a diverse population of 16,500 patients within the surrounding areas of Dunham Massey, Broadheath, Hale and Bowden. The practice is fully computerised and registered under the Data Protection Act 1984.

Patients have access to 11 GPs of mixed gender, two practice managers, a team of five nurses and a health care assistant. There are also several reception and administration staff. This is a training practice and offer appointments with trainee GPs who are clinically monitored.

The practice was open on Monday to Friday from 7.30am until 7pm. One day of the week (alternate days, unspecified) the surgery opened until 8pm. Reception staff were available from 8am until 6.30pm daily to deal with queries. Early morning (from 7.40am) and late evening (until 7.50pm) appointments were available when required. Routine appointments would be booked up to two weeks in advance and urgent cases were seen by the duty GP on the same day. Telephone consultations were also offered on a daily basis and home visits were carried out when required (usually daily), following a telephone consultation.

Facilities are available for disabled patients with disabled toilets and car parking at the rear of the building. Wheelchair access to the building is through the main entrance.

Services include family planning, antenatal, diabetic, asthma, cardiac, chronic obstructive pulmonary disease (COPD) and hypertension clinics. There are also clinics for over 75s reviews, well person clinics, smoking cessation, flu and holiday vaccinations and minor surgeries.

When the surgery is closed patients are directed to Mastercall Healthcare Limited or the local walk-in centre at Trafford General Hospital.

There were no previous performance issues or concerns about this practice prior to our inspection.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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?

Detailed findings

- 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)

Before visiting we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 8 January 2015. During our visit we spoke with a range staff including GPs, nurses, the health care assistant, administration and reception staff. We also spent the day with the practice managers who assisted us with the inspection by providing information and evidence relating to the key lines of enquiry which we followed. We held a listening event with some members of the patient population group (PPG) and reviewed CQC comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included national patient safety alerts, reported incidents and alerts on patient records. They discussed incidents, comments and complaints at weekly practice meetings with all staff and also held a daily informal GP meeting at the end of morning surgery where any staff could discuss any concerns and GPs could share good practice.

Staff we spoke with understood their responsibilities to raise concerns and knew how to report incidents and near misses. We were given an example of a major incident and were shown how this had been investigated. Action had been identified following investigation and the partners and practice manager had discussed what was required to limit the chance of the incident occurring again in the future. We saw that the incident had been documented and escalated to the Clinical Commissioning Group (CCG).

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the preceding year and we were able to review these. Significant events were a standing item on the practice staff meeting agenda and an informal meeting was held on a daily basis for GPs to discuss any concerns about their patients with each other. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. 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.

Staff used incident forms to record and report significant events and a hard copy significant event log was kept. We saw that patient alerts were noted on patient records and any prescription errors were flagged on the clinical system (EMIS web). The practice worked closely with local pharmacies to minimise errors in medication and information was cascaded to all staff at regular staff meetings. We saw that where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken. We also saw that local protocols were introduced to minimise the risk of the event happening again in the future and these were shared with the CCG to enhance good practice across the board.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. All staff were trained to a level appropriate to their role and we saw that the practice manager kept a record of all staff training so that they could be reminded when they were due to be renewed. Staff spoken with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had an appointed dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the required knowledge to enable them to fulfil this role. Most staff were aware of the safeguarding lead and all staff spoken with knew how to report an incident if they were concerned.

There was a system to highlight vulnerable patients on the practice's electronic records. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. Information was available to make staff aware of any relevant issues when patients attended appointments. The practice were still getting used to the new electronic patient system (EMIS web) and were continually looking at ways to ensure alerts were visible when the patient record was opened and the internal messaging system was being used for alerts which required an immediate response.

Are services safe?

GPs supplied information as requested to local case conferences for patients registered at their practice and attended meetings if their workload allowed. We were told of a safeguarding incident and saw evidence of the same recorded on the patient record. The records corroborated what we had been told and we saw that the incident had been followed through time. The practice nurses also provided examples of safeguarding issues and excellent communication within the practice to follow up any issues.

There was a chaperone notice and policy, which was visible in the waiting room and in consulting rooms. (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). The nursing staff usually acted as chaperone; however reception staff would act as a chaperone if nursing staff were not available. Receptionists had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Disclosure and Barring Service (DBS) checks had been carried out on any staff required to carry out chaperone duties. The chaperone policy was also part of a locum checklist so that locums were aware of the procedure within the practice.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. Medicines in the GPs bags were also checked and they were found to be in date. Medicines were not routinely stored in GP bags but were collected to be taken on home visits when thought necessary. Some medicines were stored in the GPs rooms and these were kept in locked drawers. On inspection these were also found to be appropriately kept, regularly checked and in date.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked including the ones held in doctor's bags were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice worked closely with the medicine management team. We saw the practice prescribing budget summary to 31 October 2014 and noted that a saving of £154,000 had been made to the CCG due to good management, close working with the medicines management team and regular review of medicines which were over or under prescribed. We saw that prescribing was discussed and saw that changes were made only where these were beneficial to the patients.

We saw an audit which had been carried out to see whether the practice were adhering to guidelines in respect of the prescription of methotrexate and azathioprine, drugs used in the cases of rheumatism. We saw that actions were identified and a protocol put in place to ensure that where this medication was prescribed, patients were made aware of any risks involved and these were noted on the patient record.

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

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw that blank prescription forms were kept in a locked drawer and prescriptions used in the electronic system were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Patients on repeat prescriptions were called for an annual appoint to review their medication and make sure it was still required.

On review of patient records we saw that patients were receiving the right medicines at the right time for the right conditions.

Cleanliness and infection control

We observed the premises to be clean and tidy. Cleaning was carried out by an external provider, 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.

The practice had a lead for infection prevention and control (IPC) who had undertaken training to enable them to provide advice on the practice infection control policy. However not all staff were aware who was the lead for IPC and the nursing staff spoken to on the day felt they were responsible for their own areas. The IPC policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. This provided guidance on specific situations, for example, use of personal protective equipment, dealing with spillage of blood and responding to a needle stick injury. We saw there were adequate supplies of equipment available to staff to enable them to follow the protocols. Staff were able to describe how they would use these to comply with the practice's infection control policy

Most staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the practice had requested support from the CCG to carry out an IPC audit of the practice within the last twelve months and an action plan with improvements identified for action had been completed on time. Minutes of practice meetings showed that the findings of the audits were discussed with all staff groups. The audit was due for repeat in 2015 to ensure compliance was being maintained.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand gel and hand towel dispensers were available in treatment rooms.

The practice had systems in place for segregation of clinical and non-clinical waste. There were sharps bins in each treatment room which were not readily accessible to patients. An external contractor attended the practice on a regular basis to collect clinical waste and remove it off site for safe disposal.

Clinical staff were responsible for maintaining infection control measures within their own consultation and treatment rooms during the course of the day. Regular audit was being implemented by the new health care assistant and any actions were addressed in a timely manner.

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 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.

All equipment used for minor surgery was single use and was checked for expiry date before use and safely and securely disposed of after use in line with practice policy.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the DBS. 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 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. A salaried GP was recently employed for three months to cover when longer than anticipated leave was required for one of the partners. The senior GP partner had recently left the practice and another GP had stepped informally into the role to ensure that cover was provided.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual

staffing levels and skill mix were in line with planned staffing requirements. A new practice nurse had recently been employed. However it was clear from discussion with the partners and with the nursing team that there was a requirement for still more nursing hours. Because of low national recruitment and a lack of trained nurses the practice were considering recruitment of an additional health care assistant.

Locums were used from time to time and a list of locum GPs was maintained by the practice manager so as to ensure consistency. We saw the pack which was provided to locums working at the practice which included information about where to get prescriptions, how to write referral letters, and processes for pathology and radiology. Documentation required for locums before they started work with the practice included General Medical Council (GMG) Registration, Defence Body Cover, PCT Performers List, a curriculum vitae plus two references and immunisation status including Hep B. They also had to provide evidence that their safeguarding training was up to date and they were DBS checked.

Monitoring safety and responding to risk

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

Identified risks were included on a risk log. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared findings from an infection control audit with the team. We also saw examples of clinical and staffing risks which were identified, shared with relevant staff and monitored to reduce the impact on the practice and the patients.

All patients requesting urgent on the day appointments were seen at some point during the day of their request. These appointments were designed to address specific urgent issues that could not wait for a routine appointment.

The practice had clear guidelines on repeat prescriptions for patients with long standing conditions and checks were made to ensure the patients were managed within these guidelines. Patients on complex or restrictive medication were given limited amounts of their medication to ensure safety of the person and the medicine. An example of this was antidepressant medication which was only given in sufficient amounts before the patient was due to be seen for review.

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.

We saw signs showing the location of the emergency resuscitation trolley, first aid kits and accident book. There was also information about how to use the panic button in the event of emergency. This was located on each computer and would send an alert to all other staff in the practice. This information was also detailed in the packs provided to locums.

There was an up to date business continuity plan (BCP) which set out the major perceived threats to the practice's normal ways of working. It clearly detailed the action plans, people to contact and action to be taken to deal with any issue that might occur. Staff were aware of the plan and what to do in the event of emergency. There was a separate BCP in the event of a pandemic flu outbreak. Actions included making sure that all staff were vaccinated, a separate patient waiting room would be arranged and extra personal protective equipment for staff would be ordered. The practice manager was the lead for ensuring these things happened. Staff we spoke with were aware of this but had not known of any need for it to be used.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The GPs did not routinely carry stocks of medicines for the treatment of emergencies on home visits. However patient symptoms were reviewed before the visit and specific medicines would be taken if felt required, such as if a child had a sever temperature or unidentified rash.

Are services safe?

Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that fire drills were undertaken. Risks associated with service and staffing changes (both planned and unplanned) were monitored. We saw that staff were able to cover each other when required and specifically saw that GPs had covered each other during long term unplanned absence.

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 treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs told us they led 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 continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The practice were part of peer review within the Clinical Commissioning Group (CCG) which looked at the quality of their referrals and audited whether or not they were appropriate. The senior GP partner showed us data from the local CCG which compared them with 34 of their peers. We saw that they were highest for quality and appropriateness of referrals to other health and social care providers at 87.7% compared to the lowest which was 38%.

The practice had also completed a review of case notes for patients discharged from hospital on anticoagulant medication. The review had highlighted the need for new protocol which had been introduced to ensure that all patients discharged on Warfarin knew what their blood levels were on discharge and when they needed to be checked again.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice showed us three clinical audits that had been undertaken in the last year. One of these was a completed audit about joint injections where the practice was able to demonstrate the changes resulting since the initial audit. The audit demonstrated good quality care in the area of joint injections and identified action to be taken to improve data collection such as the introduction of patient satisfaction questionnaires. Other examples included reviews of case notes which resulted in a change in protocol for patients discharged from hospital on an anti-coagulant medicine.

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). For example, we saw an audit regarding the prescribing of Disease-modifying antirheumatic drugs (DMARDs). Following the audit, the GPs carried out medicine reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

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. This benchmarking data showed the practice had outcomes that were comparable or better than other services in the area, for example regarding referrals to secondary services. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice was above the average minimum standard of 80% in relation to cervical screening for the year 2014/15 and had increased its baseline by 1.24% compared to previous years.

Are services effective?

(for example, treatment is effective)

The practice were involved in the A&E deflection initiative with the local CCG and explained a process introduced to reduce the number of inappropriate attendances at A&E. This involved a direct telephone line and immediate access to a GP for referral back to the practice of any patients who attended A&E inappropriately. However, they found that the service was barely utilised highlighting that very few attendances at A&E by patients of the practice were inappropriate.

The practice had introduced a "quality stateboard" which provided a RAG (red/amber/green) system to monitor the quality of service provided to the patients. It was positioned where it could be seen by all staff and showed the next available telephone consult or appointment with a GP or nurse. It highlighted the average waiting time for incoming calls and the number of calls taken each day. It also showed waiting times for routine and urgent referral letters, scanning and prescriptions. The information was collated each day by the head receptionist and the phone call data was transferred to a stateboard in the patient waiting area for patients to see along with DNA figures collated weekly. The information was used to encourage staff to self-monitor and create improvement, specifically when categories dropped into 'red'.

Effective staffing

We saw that appraisals were carried out annually on all staff and training plans and personal objectives were respected and encouraged. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example they had recently introduced 'counter terrorism and anti-radicalisation of vulnerable people' training for all staff. 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 through a quality improvement report from the University of Manchester for the year 2013-14. The feedback had been given by year 1-5 students on their community placements at the practice.

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. One of the GPs had a specific interest in learning disabilities and we saw three examples where this interest and knowledge had provided positive outcomes for patients. 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).

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles such as review of patients with long term conditions were also able to demonstrate that they had appropriate training to fulfil these roles. However we saw (and the practice was aware) that nursing hours were limited for the amount of registered patients with long term conditions and nursing needs and this was being addressed.

We were shown an excellent example where poor performance had been identified and appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' 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 and out-of-hours GP services both electronically and by fax. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. 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 appropriately.

The practice held regular multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. Consultation with other health and social care professionals about patients included work with district nurses, social services, mental health teams, out of hours staff, infection control professionals and intermediate/

secondary care. We saw the forms used to share and record this information on the notes of a patient who required input from an infection control professional. The practice also worked with the local pharmacy and medicine management team to ensure that patients were receiving the right medication at the right time to suit the conditions or illnesses they were experiencing. This included review and change of medication if multiple conditions developed.

In addition the GPs worked collaboratively with a company of GPs in Trafford looking at integrated care, and trying to work together to provide integrated care services in the NHS for the population of the community.

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. Electronic systems were also in place for making referrals, and the practice made approximately 2,243 referrals between May and December through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

Patients referred to A&E were provided with a summary from the electronic system and staff told us that the GP often also wrote an additional letter to ensure that all information was available. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

There were systems in place to provide staff with the information they needed. Staff used an electronic patient (EMIS web) to coordinate, document and manage patients' care. This had been recently integrated and all staff were fully trained on the system. Further training was available for staff until they became fluent in the systems functionality and they 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. We saw that read audits were carried out to ensure security of the patient record. However we did not see that regular checks were carried out to ensure that information on patient records (such as read codes and summaries) were kept up to date or to identify any shortcomings .

Consent to care and treatment

Although there was a consent policy in place for the practice and protocol for staff to follow with regards to obtaining consent for things such as joint injections and immunisations, we did not see a policy which highlighted the different types of consent such as 'informed' or 'complied' consent, the Mental Capacity Act 2005, or Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

We found that the clinical and medical staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it and we saw examples where treatment was provided in a patient's best interest where they lacked capacity to make their own decisions. Clinical staff were also able to provide examples which showed good understanding of Gillick competencies and consent for children. However not all reception and administration staff were knowledgeable about the Mental Capacity Act 2005 and Gillick competencies and felt that this knowledge was not required in their role.

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. One of the GPs had a specific interest in patients with learning disabilities and we saw two examples where the patients' care and treatment had been altered, or where best interest meetings had been held, with a positive outcome for the patients concerned. In particular, the GP had taken one patient's social needs and academic abilities into consideration and had helped to introduce them to sports clubs and universities to make use of the positive things they were able to do and dramatically improve their quality of life, which previously had been particularly poor.

Health promotion and prevention

Are services effective?

(for example, treatment is effective)

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 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. They kept a register of all patients with a learning disability who were offered an annual health check. The practice's performance for cervical smear uptake was 81.4%, which was better than some others in the CCG area. The health care assistant was responsible for following up patients who did not attend screening and new patient health checks were offered by the practice nurse.

There was a substantial amount of information about health promotion and other signposting information spread across a lot of varying noticeboards in the waiting room. Some patients commented that the information was confusing and we discussed during feedback how this could be altered to be more informative for the patients. There was also a considerable amount of health information on the practice website about asthma, blood pressure, bowel and cervical screening, contraception, counselling, diabetes, heart disease and stroke.

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, the results of which were published on 8 January 2015, patient satisfaction surveys undertaken by the practice relating to flu and shingles clinics and online booking services, audits carried out by medical students of complaints and comments from patients, and a report following a patient satisfaction questionnaire carried out in 2013/14 about the overall service provided by the practice. 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 better than average by patients because 93% said the last GP they saw or spoke to was good at listening to them compared to the local Clinical Commissioning Group (CCG) average of 89%.

Most patients we spoke with felt the practice offered an excellent service and staff were efficient, helpful and caring. However, we received negative feedback from one patient who was concerned that they could no longer see the GP of their preferred choice when they wanted to do so, unless they booked this appointment several days in advance. Patients reported that staff treated them with dignity and respect. We spoke with ten patients in total on the day of the inspection.

There was no glass partition to help keep information private at reception but a 'privacy line' had been introduced to encourage patients to leave enough space when queuing. However, we noticed on the day that the line was not big enough and 'compact queuing' was encouraged due to the proximity of reception which was very close to the entrance. Patient conversations were overheard from area. However, we saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments at reception so that confidential information was kept private as much as possible and the practice switchboard was located upstairs which was completely away from the reception desk.

There was a clearly visible photo board in the patient reception area with photographs of staff and their roles within the practice. However one patient mentioned that they did not know what each role meant and what their purpose was within the practice. During feedback we discussed ways in which this facility could be improved to increase patients' knowledge and encourage them to take queries, concerns or comments to the correct and responsible member of staff.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 93% of practice respondents said the GP involved them in care decisions and 99% had confidence or trust in the last GP they spoke to. 87% felt the GP was good at explaining treatment and results.

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.

Patient/carer support to cope emotionally with care and treatment

We saw evidence that all the staff were able to provide emotional support. One of the GPs described incidences when they had gone over and above expectation to support a person with their treatment. Patients we spoke to said they always had enough time to discuss their problems and could make longer appointments if they needed them. We saw that staff who spoke with patients over the telephone were knowledgeable and helpful and were able to conclude some consultations without the need to bother a GP or nurse. These included discussions around repeat prescriptions, queries about test results and how to access secondary services or other support services available.

Are services caring?

Counselling and psychological well-being services were available within the CCG and the waiting times for these services and for cognitive behaviour therapies (CBT) were well below the national average at 8 weeks and 5-6 weeks respectively. Bereavement counselling was offered by the GPs and patients were referred on to services at Trafford General Hospital if felt appropriate.

Notices in the patient waiting room, on the TV screen and patient website told patients how to access a number of support groups and organisations.

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 a number of 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 implemented many suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example medical students had undertaken an intense in-house patient survey about the appointment system. The results were discussed with the doctors and practice manager and changes were made so that appointments were more comparable with patients' requirements.

'Hot clinics' had been introduced for children under the age of 5 years and these were available both in the mornings and after school hours.

An intense on call/duty doctor regime for patients who required to be seen on the day for more urgent issues can be given an appointment or triaged by a doctor over the telephone. Emphasis was being given on the provision of more telephone consultations and 48 hour appointment booking had been increased. A flow chart had been created to assist staff in establishing the patient's need for a telephone consultation or face to face visit.

The number of staff on the telephones had been increased during peak periods such as between 8am and 10am each morning when all staff were available to take calls from patients. This had relieved the queuing time on the phone for patients booking appointments or wanting to speak about other things.

With regards to prescription issues, better working with the medicines management team and the prescription team had led to enhanced training for staff. Prescriptions turnaround was 48 hours for routine repeats and 24 hours for more urgent requests. A separate prescription area has been created in the foyer so there is no need for patients to queue at reception. Staff were trying to contact patients when there were issues with their prescriptions before they turned up at the surgery for collection. However this was not always possible due to the number of requests received.

Also at patients' requests dog hooks and bicycle rack facilities had been made available and outdoor lighting had been updated so as to provide a safely lit area for patients accessing the disabled car parking.

The practice had a very high prevalence of patients in nursing homes and were working closely with the Clinical Commissioning Group (CCG) to reinstate the 'nursing home GP' a service funded for in the previous year which had highlighted positive outcomes for the nursing home patients and for the practice in terms of clinical time. In the meantime they were trying to introduce a service by the nurse to bridge this much needed gap.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services such as those with a learning disability, frailty, end of life and the homeless. The practice had access to online and telephone translation services. Staff were provided equality and diversity training through e-learning and those we spoke with confirmed that they had completed the training and were knowledgeable in the subject.

The premises and services had been adapted to meet the needs of patient with disabilities such as ground floor consulting rooms, a hearing loop, provision for wheelchairs with ramp access, wide doors, a reception desk at lower level, and outdoor lighting. Doors were not automatic but the reception window was such that patients who required assistance could be seen when they arrived and assistance was given when required.

Access to the service

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice but one toilet served all purposes including baby changing facilities. The toilet was accessible via the baby changing facility which meant that when they were being used the toilet was locked. There was no chair for breast feeding and no separate sink or bin in the baby changing area.

Are services responsive to people's needs?

(for example, to feedback?)

Patients had access to 11 GPs of mixed gender, two practice managers, a team of five nurses and a health care assistant. There were also several reception and administration staff. This was a training practice and offered appointments with trainee GPs who were clinically monitored.

The practice was open on Monday to Friday from 7.30am until 7pm. One day of the week (alternate days, unspecified) the surgery opened until 8pm. Reception staff were available from 8am until 6.30pm daily to deal with queries. Early morning (from 7.40am) and late evening (until 7.50pm) appointments were available when required. Routine appointments would be booked up to two weeks in advance and urgent cases were seen by the duty GP on the same day. Telephone consultations were also offered on a daily basis and home visits were carried out when required (usually daily), following a telephone consultation.

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 such as information in the waiting area and the practice booklet which is provided to patients on new registration. Patients we spoke with were aware of the process to follow if they wished to make a complaint and most said they would refer any concerns to reception staff or the GP they were consulting with. None of the patients we spoke with had ever needed to make a complaint about the practice.

We reviewed the practice complaints log which identified 13 complaints received since 1 April 2014. We saw that these were handed appropriately and dealt with in a timely way. The practice had been open and transparent when dealing with the information received and reviewing the situation.

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. We saw that two of the complaints had involved discussed with the medicines management team and that all complaints were reported to Trafford CCG as part of the practice complaints annual return. Minutes of practice meetings showed that complaints were discussed to ensure all staff were able to learn and contribute to any improvement action that might be required.

Are services well-led?

(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 did not see any clear written vision and values displayed in the waiting area. However we spoke with 11 clinical and administrative staff and all were clear that the practice aim was to offer friendly, caring and good quality service that was accessible to all patients. One GP we spoke with told us that although they did not know of a formal vision, they all aimed to provide good quality care to their patients and felt they had the best staff doing the best jobs in sometimes difficult circumstances.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on their computers and within the practice manager's office. We looked at eight of these policies and procedures and saw they had been reviewed regularly and were up to date.

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 GP lead for safeguarding. All staff spoken with were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it 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 lead GP told us about peer review within the practice and local peer review within the CCG which looked at eight national scorecards to benchmark performance. The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken such as reductions in prescribing or checklists for patients being discharged from hospital on specific medication such as warfarin.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the ongoing work schedule, which addressed a wide range of potential issues in relation to infection control, emergency medicines, sharing of information and chid protection. We saw that the risks were regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

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

Leadership, openness and transparency

The practice manager undertook appraisals for the reception and administration staff and the nursing/clinical staff were appraised by one of the GPs. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. Clinicians received appraisal through the revalidation process. The practice manager was appraised by the lead GP and we saw evidence that all staff had been appraised in June 2014. We also saw that dates for 2015 were being arranged.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that practice training and away days were held monthly when the practice was closed on a Wednesday afternoon and all staff attended.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, management of sickness and whistleblowing which were in place to support staff. Staff spoken to were aware of the policies and knew how to access them when required.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through questionnaires carried out by medical students and surveys undertaken by the patient participation group (PPG). There was a physical and a virtual PPG and we spoke with five members from the virtual group. However, none of them were clear about their role and said they were not representative of the patient population in that they did not receive information from or provide information to other patients. We clarified this with the practice manager

Are services well-led?

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

who explained the patients we had spoken to were not part of the physical group and were used simply to undertake and respond to questionnaires. Results of the patient survey and action plan were displayed in the waiting room and on the surgery website. They were also emailed to the virtual patient group but those we spoke to said they had not received it. During feedback we discussed ways in which their role could be better defined and explained to them for the future as all were keen to continue being a part of this service.

The practice manager showed us a number of improvements that had been made to the practice on feedback from patients. For example, changes in reception to provide areas specifically for requesting prescriptions and bringing in samples which had reduced queuing at the reception desk, redecoration of the waiting area, posters to advise people that where they can hold private conversations and dog hooks and bicycle rack facilities outside the practice.

The practice had also introduced a positive feedback board for the practice team in the administrative area of the practice. We saw several comments of appreciation and thank you cards displayed there.

Management lead through learning and improvement

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

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings to ensure the practice improved outcomes for patients. For example the over prescription of a controlled drug which was highlighted by the medicines management. Investigations were undertaken by the practice, medicines management and NHS England. The outcome led to a change in practice policy around prescribing and NHS England asked this new policy to be used as evidence of best practice.

The practice were involved in the teaching and education of future doctors and GPs and were an active undergraduate training practice. This included the teaching of a variety of medical students ranging from Year 1 to Year 4. The programme involved all of the GPs and clinical staff at the practice. A GP trainee had joined the practice in August 2014 as a specialist trainee in general practice. This GP trainee would complete their post graduate training and would be mentored by two of the practice partners who were the GP trainers.