Deane 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	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Good ●
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Deane Medical Centre on 18 December 2015. Overall the practice is rated as outstanding.

We found the practice to be outstanding the domains for providing safe, effective and well-led services. It was found to be good for providing safe and effective services.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them. This included having a website where each page could be translated into many different languages.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

Summary of findings

- In addition to safeguarding training for adults and children staff had received training in how to recognise domestic violence and how to identify signs of female genital mutilation (FGM). Awareness training focussed on the diverse cultures of the patients of the practice.
- A non-English Speaking Patient (NESP) support worker worked from the practice. They were able to translate for patients but also worked with families and individuals to educate them in health matters and how the NHS worked. The practice had been proactive in organising the service as an innotive way of meeting the needs of their patient population.
- The GPs and practice nurses arranged meetings for other clinicians in the area. These were used to share good practice, collectively discuss serious untoward incidents and significant events, and take part in training sessions as part of their continuing professional development (CPD).
- Patients with a learning disability, mental health needs or Dementia were invited for an annual review of their physical and mental health needs. Dual appointments with the GP and nurse were arranged and the clinicians used a template to identify all health needs and issues. This decreased the number of appointments required for the patients. They also involved the patients' carers where appropriate and consent had been given so convenient appointments that were less likely to be missed were arranged.
- The nurse ran a drop in centre for students at the university. Any student could attend, including patients of other practices. Where appropriate patients were signposted to the most appropriate service, and their healthcare needs could be met by the nurse if possible. There was evidence of mental health issues being identified during these drop in sessions.
- A GP telephoned a care home every Friday to see if they had any concerns that required attention before the weekend. The home provided feedback to us, stating that a GP visited at least once a week, had a walk around to see any patient who required attention, and involved patients in their care planning.

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?

Outstanding ☆

The practice is rated as outstanding for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.

Are services effective?

Outstanding ☆

The practice is rated as outstanding for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. The practice was using innovative and proactive methods to improve patient outcomes and it was proactive in engaging with other local providers to share best practice.

Are services caring?

Good ●

The practice is rated as good for providing caring services. Feedback from patients obtained from CQC comments cards and speaking with patients about their care and treatment was consistently and strongly positive, although feedback from the GP national patient survey was less positive. 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. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Summary of findings

Patients told us it was easy to get an appointment with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and staff from other practices, and a high level of staff satisfaction. The practice had an active patient participation group (PPG) that was representative of their patient population.

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

Outstanding ☆

The practice is rated as outstanding for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice had a register of patients over the age of 75 and these patients had a named GP. All patients over the age of 75 were invited for a health check.

Patients at risk of an unplanned hospital admission had a care plan in place. This was regularly monitored and updated and the practice found other areas of ill health were identified as a result of reviewing care plans. The practice provided 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.

A GP telephoned a care home every Friday to see if they had any concerns that required attention before the weekend. The home provided feedback to us, stating that a GP visited at least once a week, had a walk around to see any patient who required attention, and involved patients in their care planning.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long-term conditions. Longer appointments and home visits were available when needed. All patients with a long term condition had a structured annual review to check that their health and medication needs were being met. Care plans were in place for those at a higher risk of an unplanned hospital admission. We saw these were very detailed and well managed, with regular reviews taking place. We saw evidence that other areas of ill health were highlighted as part of the care planning so all the patient's needs could be looked after. 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

Outstanding ☆

The practice is rated as outstanding 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. Staff had received training on recognising abuse. Staff had a good awareness of cultural differences in their patient population. A specialist support worker based at the practice was able to communicate

Summary of findings

effectively with families who did not speak English, providing healthcare education when needed. Immunisation rates were relatively high for all standard childhood immunisations and we saw evidence these were improving.

Staff were aware of the circumstances when young people could be seen without an adult being present, and where a young person's understanding was in doubt referrals were made to a local young person's centre. Appointments were available outside school hours and children were always seen on the day an appointment was requested. We saw good examples of the practice working with midwives and community nurses.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding 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 to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering a full range of health promotion and screening that reflects the needs for this age group. This included health checks specifically for the 40 to 70 age group.

The practice had a drop in clinic for students. This had started as a sexual health clinic but audits showed other illnesses, particular mental health issues, were identified during the clinics. Patients were then directed to the most appropriate provider. Extended hours appointments were available once a week.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. Patients with a learning disability had an annual health check. The practice ensures all necessary checks with the GP or nurse were arranged for the same appointment to avoid multiple visits to the practice.

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.

Summary of findings

A high percentage of patients did not speak English as their first language. The practice worked with a specialist support worker who provided education and translation services. Since the scheme started they said that the number of inappropriate A&E attendances and missed appointments had decreased, and the number of childhood vaccinations and health checks such as cervical smears had increased.

People experiencing poor mental health (including people with dementia)

Outstanding 

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health received an annual health check. The practice routinely incorporated mental and physical health checks into the same appointment to minimise the number of times patients needed to attend. They followed a checklist to help identified any health needs during each appointment. 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

What people who use the service say

We reviewed 33 CQC comments cards completed by patients prior to our inspection. We spoke with six patients during our inspection but most of the patients at the practice spoke limited English.

The comments cards and feedback from patients was extremely positive. We received no negative comments, with most patients telling us they were treated at the time they required an appointment by friendly competent staff. They told us health checks were carried out and they were referred to other services for investigation when this was appropriate.

We also looked at the 2014 practice patient survey. This showed that the majority of patients who responded were treated with dignity and respect by all staff, had confidence and trust in the GPs and nurses, and were happy with the practice environment.

The results of the national GP survey were less positive in some areas when compared to the rest of the clinical commissioning group (CCG). These areas included patients being treated with care and concern by the GP, and the GP involving patients in decisions about their care. However our findings during the inspection were not reflective of these results.

Outstanding practice

- In addition to safeguarding training for adults and children staff had received training in how to recognise domestic violence and how to identify signs of female genital mutilation (FGM). Awareness training focussed on the diverse cultures of the patients of the practice.
- A non-English Speaking Patient (NESP) support worker worked from the practice. They were able to translate for patients but also worked with families and individuals to educate them in health matters and how the NHS worked. The practice had been proactive in organising the service as an innovative way of meeting the needs of their patient population.
- The GPs and practice nurses arranged meetings for other clinicians in the area. These were used to share good practice, collectively discuss serious untoward incidents and significant events, and take part in training sessions as part of their continuing professional development (CPD).
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Deane Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included a GP and an expert by experience.

Background to Deane Medical Centre

Deane Medical Centre is based on a main road near the centre of Bolton and close to the University of Bolton. Primary care is delivered to 3268 patients. The practice has a General Medical Services (GMS) contract with NHS England. It is a training practice for student doctors and nurses.

Appointments were available from 8am until 6.30pm Tuesday to Friday and from 8am until 8pm on Mondays.

There are two GPs working at the practice and a locum works when required. Also working at the practice is an advanced practitioner, a nurse practitioner, a practice nurse, two healthcare assistants, a practice manager and other administrative and reception staff.

Approximately 80% of patients were from a black and minority ethnic (BME) background, and approximately 50% of these did not speak English.

Access to a GP out-of-hours was provided through NHS 111 and the GP out of hours service provider.

Why we carried out this inspection

We inspected this service as part of our 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.

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. These groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)

Detailed findings

- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before our inspection we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We asked Bolton Clinical Commissioning Group to tell us what they knew about the practice and the service provided. We reviewed some policies and procedures and other information received from the practice prior to the inspection. The information reviewed did not highlight any areas of risk across the five key question areas.

We carried out an announced inspection on 18 December 2014. During our inspection we spoke with staff including GPs, nurses, a healthcare assistant and reception staff. We also spoke with six patients. We observed interaction between staff and patients in the waiting room.

Outstanding ☆

Are services safe?

Our findings

Safe track record

We saw evidence that the practice had a good track record for maintaining patient safety. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that significant events were appropriately identified and reported. GPs told us they completed incident reports and carried out significant event analysis as part of their on-going professional development. They showed us examples of significant events that had been reported to NHS England using the incident reporting system. All significant events had been analysed to ensure the risk of reoccurrence was reduced. We saw an example of a significant event being shared with GPs from other practices in the area. The practice arranged meetings for other GPs and practices, held at Deane Medical Centre, so any safety information could be discussed and shared.

The GPs, nurses and other staff discussed significant events at their regular meetings. The meeting minutes we reviewed provided evidence of new guidelines, complaints, and incidents being discussed positively and openly.

All the staff we spoke with, including reception staff, were aware of the significant event policy and knew how to report and escalate any incidents. They were aware of the forms they were required to complete and knew who to report any incidents to at the practice. All safety alerts were kept in a 'communications bible' accessible to all staff. We saw evidence that these were shared with all staff during the regular meetings.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw evidence to confirm that staff had completed a significant event analysis which included identifying any learning from the incident.

We saw evidence to confirm that, as individuals and as a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made. Significant events, incidents and complaints were investigated and reflected on by the GPs and the practice manager. We saw examples where processes had been changed following incidents being reported. These included changing the way some medical students worked and checking surgery lists during each session to ensure all triage telephone calls had been made.

We reviewed the significant events that had been reported during the year prior to our inspection. These had all been considered and the action taken had been recorded. Significant events and incidents had been discussed by appropriate staff at the practice in an open way. Staff told us there was a very open and blame-free culture where they were encouraged to report and learn from incidents. We also saw evidence that incidents were shared with the clinical commissioning group (CCG) appropriately. The practice liaised with the CCG regularly following the reporting of one incident so that up to date advice was provided until the issue was resolved. This learning was then shared with other practices during the meetings for GPs and nurses arranged by the practice.

GPs from other practices in the area were invited to meetings where safety incidents were openly discussed. This was so other providers also learnt from incidents and took action to reduce the risk of the events re-occurring.

Reliable safety systems and processes including safeguarding

The practice had up to date safeguarding policies for children and vulnerable adults. This had been put in place following discussions with the CCG to ensure the information was correct. The advanced nurse practitioner was the lead for safeguarding, and a GP and the practice manager acting as deputies. We looked at training records which showed that all staff had received relevant role specific training on safeguarding, with the safeguarding lead and GP being trained to a higher level. The practice manager had also attended a safeguarding course at The University of Bolton. They were in the process of arranging for other staff to attend as they had found it beneficial. All staff had been given a short hand-out on safeguarding that they could keep on their person. This gave brief information and referred them to more in-depth policies that could be consulted when required.

In addition to safeguarding training all staff had received awareness training in domestic violence and female genital mutilation (FGM). This was due to be repeated in January 2015. Staff had been trained about the language to use if they needed to discuss FGM with patients, and they were aware of cultural differences and attitudes. Staff were also

aware of the need to be alert about adults travelling abroad with children, especially during the summer holidays. There was a system used for reporting suspected cases of FGM and the practice received information from the Royal Bolton Hospital about the prevalence of cases found within the hospital setting. The GPs explained that there was a balance between cultural differences and safeguarding issues and they knew who to approach for advice if they were unsure.

All the staff we spoke with were able to discuss what constituted a child and adult safeguarding concern. They were aware of how to report suspected abuse and who to contact if they needed advice. We were given examples of safeguarding concerns being raised with the relevant authorities and how the practice had been involved in managing these concerns. We saw that safeguarding was an agenda item for the regular clinical and practice meetings.

There was an up to date chaperone policy in place. This provided clear information about why chaperones could be required and what was expected from a chaperone. It also included the role of interpreters if required while chaperoning. Chaperones were encouraged for intimate examinations. They were also offered for example when using a stethoscope to listen to a patient's heart. Staff were aware of cultural differences and the need to ensure patients felt comfortable during any type of examination. All staff had received training in chaperoning and all were aware of their role and where they should be positioned during an examination of any kind.

A record was kept detailing patients who had a care plan in place. These records also included safeguarding information and acted as a prompt to ensure safeguarding issues were always considered.

Medicines management

There were clear systems in place for medicine management. If patients required medicines on a repeat prescription these were re-authorised by a GP at least once a year following a medicine review.

All prescriptions were printed and there were checks in place to ensure prescriptions were secure. Reception staff were aware of questions to ask to ensure the security of prescriptions being collected by patients.

We saw there were medicines management policies in place, and the staff we spoke with were familiar with these.

We checked the medicines held at the practice. These were all appropriately stored. Medicines to be used in the case of an emergency were kept in a safe in the nurse's room. Appropriate staff had access to these. We saw that these were checked by the advanced nurse practitioner to ensure they were available and within their expiry date. There was a system in place to re-order medicines when their expiry date was approaching. Clear records were kept whenever medicines were used. Controlled drugs were not held at the practice. All the medicines we checked, including medicines held in the GPs' bags, were appropriate and within their expiry dates.

Some medicines and vaccines were kept in a fridge. The fridge temperature was monitored daily and the temperature recorded. The staff we spoke with were aware of the action to take if the temperature went outside the required range. Meeting minutes provided evidence that this procedure was discussed during practice meetings. The practice nurse rotated medicines to ensure they were used in date order.

Evidence was seen of medicine audits being carried out. The practice was responsive when new advice was received and carried out medicine audits appropriately. We saw evidence that changes to medicine prescribing were made when required. These were carried out in response to new advice, including about long term use, and we saw changes to prescribing were made where required.

A medicines management technician from the CCG attended the practice weekly. They checked prescribing, carried out quality audits and gave advice. We spoke with the medicines management technician during our inspection. They had attended to help with changes to prescriptions following pharmacies being unable to obtain a certain medicine. They told us that their audits found possible financial savings were sometimes very low and this was due to appropriate prescribing taking place.

Cleanliness and infection control

During our inspection we looked at all areas of the practice, including the GP surgeries, nurses' treatment rooms, patients' toilets and waiting areas. All appeared visibly clean and were uncluttered. The patients we spoke with commented that the practice was clean and appeared hygienic.

A cleaner was employed directly by the practice. They attended daily and their hours had recently been increased

from two and a half hours a day to four hours a day. We saw there was a cleaning schedule in place. This detailed what cleaning would be carried out on a daily, weekly, monthly and less frequent basis. The practice manager and advanced nurse practitioner carried out daily checks on different areas of the practice to ensure everything was in order. However, they told us cleaning was carried out to a high standard and they spoke to the cleaner immediately if there was anything further than required attention. In addition the practice had introduced 'Tidy Friday' where once a week staff ensured areas such as the staff room were cleared and all perishables were removed from the food fridge so it could be cleaned.

We saw there was an up to date comprehensive infection control policy. One of the practice nurses took the lead for infection control. All staff had received in-depth infection control training from the lead at Bolton CCG. We saw that this training was regularly updated. We saw evidence that information relating to the prevention and control of infection was discussed during practice meetings to ensure staff were kept up to date with the latest guidance. This included guidance provided by the infection control lead around the handling of specimens.

We saw there were hand washing facilities in each surgery and treatment room and instructions about hand hygiene were displayed. Hand wash and paper towels were next to each hand wash basin, and hand gel was available throughout the practice. Protective equipment such as gloves, aprons and masks were readily available. Curtains around examination couches were disposable and had been replaced in December 2014. Examination couches were washable and were all in good condition.

An infection control audit had been carried out in October 2014. We saw some areas for improvement had been identified. These included replacing some hand wash basins and replacing some flooring. We saw evidence that builders had been sourced and work to make the improvements had commenced. The infection control lead had carried out a hand hygiene audit approximately six months prior to our inspection. Hand gel had been placed throughout the practice and staff were encouraged to use this.

The practice was working with an external company to carry out legionella testing. The company was assessing the piping throughout the practice then a test would be carried out.

Equipment

The staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw evidence that all equipment was tested and maintained regularly. Portable electrical appliance testing had been carried out during March 2014. We also saw that the calibration of equipment, such as the blood pressure monitors, was carried out at the same time.

Staffing and recruitment

The practice had an up to date recruitment policy that covered all aspects of the recruitment of staff. This included ensuring the professional registration of clinical staff was up to date, checking staff had the right to work in the UK, and obtaining Disclosure and Barring Service (DBS) checks when required. We looked at a sample of personnel files for doctors, nurses and reception staff. We saw that pre-employment checks, such as obtaining a full work history, evidence of identity, references and DBS checks where required had been carried out prior to staff starting work. There was a DBS check outstanding for a new member of the reception team. The practice manager told us this check was being obtained to ensure they were suitable to carry out chaperoning duties, and they would not be chaperoning patients until the checks had been returned.

The provider routinely checked the professional registration status of GPs and practice nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) each year to make sure they were still deemed fit to practice. Appropriate checks were also carried out when the practice employed locum GPs. The practice manager told us they only used locum GPs occasionally and they used regular ones who they knew if one was required. We saw evidence that all GPs and nurses had up to date medical indemnity insurance.

Safe staffing levels had been determined by the provider and rotas showed these were maintained. We saw there was a great deal of flexibility in the working patterns of the GPs. During busy periods they worked extra sessions to ensure all patients who needed to be seen had an appointment.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the

Are services safe?

building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. All identified risks were recorded and assessed. The practice manager ensured action was taken to reduce any of the identified risks, and all information was disseminated to staff during meetings.

A fire safety update had been provided to staff at a practice meeting on 5 November 2014. We saw evidence that fire safety equipment was checked every week, and escape routes and signage were also checked.

Arrangements to deal with emergencies and major incidents

We saw that the computers in the reception and clinical rooms had a panic button on them so staff could call for assistance in an emergency. All the staff we spoke with were aware of how to use them. All staff had received training in basic life support. We saw that oxygen was available in the practice. This was checked regularly to ensure it was ready for use, and had last been checked on the day of our inspection.

Emergency medicines were held in a secure area of the practice and all staff knew how these could be accessed. The medicines we saw were all within their expiry date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The practice manager and GPs kept a copy of this plan at their homes in case they could not access the building for any reason.

Information was available regarding how to deal with suspected Ebola cases. Protective equipment was also held that was only to be used if Ebola was suspected in a patient.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurses demonstrated how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of clinical and practice meetings where new guidelines were disseminated and the implications for the practice's performance and patients were discussed. The GPs interviewed were aware of their professional responsibilities to maintain their knowledge.

We saw that patients were appropriately referred to secondary and community care services. Referrals were discussed during clinical meetings. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. The staff we spoke with and evidence we reviewed confirmed that 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 practice coded patient records and the GPs and nurses we spoke with were all familiar with the benefits of this, but recognised further improvements could be made. To address this, they were considering appointing a staff member to ensure these improvements took place and assess the benefits for patients.

The full time GP was the lead for the majority of clinical areas and the nurses carried out regular checks on patients with long term conditions.

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. We saw that these were used as a tool to improve outcomes for patients. One example seen was a recent audit into atrial fibrillation and the use of anticoagulation. Following the audit clear pathways were developed and evidence was seen that the latest NICE guidance was implemented. The use of new anticoagulants had been initiated appropriately and benefits were being monitored. We also saw completed audits cycles around heart failure and the prescribing of painkillers, where positive outcomes for patients had been recorded.

We saw there was a clear philosophy of the practice striving to give the best possible care for their patients. The GPs explained there were significant issues with patients complying with the management of their conditions. One example was the management of diabetes and we saw evidence that patient compliance had improved following GPs and nurses specifically educating these patients about their condition.

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

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory training courses such as for basic life support and infection control. The practice manager was in the process of setting up a skills and training matrix so they could see at a glance what training each staff member had had and when it needed to be updated. Staff completed a pre and post training questionnaire so the practice manager could ensure their training needs had been met.

We saw that the continuing professional development (CPD) of the GPs and nurses was monitored and staff were encouraged to increase their knowledge and skills. One GP had been revalidated and one had a date for revalidation. They were both up to date with their appraisals. Every GP is appraised annually, and undertakes a fuller assessment

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

GPs attended regular clinical training. We saw they arranged monthly meetings, held at the practice, to which other GPs in the area were invited. Consultants were invited to discuss relevant topics and areas of learning were discussed to improve the outcomes for patients in the area.

All staff undertook annual appraisals that identified learning needs. When a training need was identified this was arranged by the practice manager. Staff told us they felt well supported at work and were able to request additional training if they thought it would be beneficial. They said the practice manager had an open door policy and either they or the GPs could be approached at any time. The practice manager, who was a trained nurse, carried out the appraisals for nursing staff. We saw evidence that their clinical competency was checked as part of the appraisal process. In addition to annual appraisals more frequent one to one meetings were held between staff and the practice manager. Although these were more informal meetings a record of what was discussed was kept.

The practice was a teaching practice for nursing and medical students. We saw positive feedback had been received from the university and the practice received a teaching certificate of excellence during October 2014. A training timetable was in place for all students and it was clear what was expected of them and what their responsibilities within the practice were. Training accreditation booklets were held for nursing and medical students so there was a record of their progress.

The practice had a staff handbook issued to all staff, with a copy also being kept behind the reception desk. New staff, including medical and nursing students, received a full orientation pack. There was an induction programme in place for new staff and a record was kept of when different aspects of their induction had been completed. The practice manager told us they tried to ensure new staff completed mandatory training within six months of starting work.

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, out-of-hours GP services and the 111 service both electronically and by post.

Regular multi-disciplinary team (MDT) meetings were attended by GPs and nurses. We saw evidence that patients who required palliative care had care plans in place from an early stage that were regularly discussed and updated by the MDT. Aspects of the care plans were given a risk rating to ensure all aspects of care were continually monitored. This ensured continuity of care at all times.

The practice worked closely with a clinical commissioning group (CCG) scheme in the area called NESP (non English speaking patients). The scheme started in May 2014 to educate patients about accessing services, booking and cancelling appointments, educate patients on health and life-style choices, increase the uptake of childhood immunisations and smear tests and encourage patients to access English classes. We spoke with the NESP support worker who covered the practice. They explained that the practice had invited them to have a base in their practice due to the number of non English speaking patients on the register. They told us patients used them as a first point of call when they attended the practice so they could receive a translation service. We saw evidence that the number of missed appointments and accident and emergency (A&E) attendances had decreased since the NESP project started. The number of women attending for smear tests had also increased. The NESP support worker told us the practice was particularly proactive in ensuring all their patients received the appropriate information and advice so all health care was available. They visited patients to give holistic advice relating to healthcare and the appointments system.

The practice worked closely with the University of Bolton, which was close by. This was initially focussed on sexual health but it had been identified by various audits carried out by the practice that students were also accessing help for issues such as mental health or depression at an early stage. The nurse held a drop in service once a week where students, including those not registered at the practice, could be signposted to other services or their own GP as appropriate. If students were behind with any of their vaccinations these were carried out at the time they attended. The practice then met bi-monthly with student liaison leads and the university chaplaincy to ensure the

health, cultural and faith needs of the students were being effectively managed. This service had been initially funded by the Primary Care Trust (PCT). PCTs were replaced by CCGs in April 2013. When the funding for the service stopped the practice decided to carry on their work due to the positive impact on patients.

The GPs arranged a monthly meeting with other GPs in the area. These meetings were held at the practice. They were an opportunity for GPs to discuss areas that may not be their speciality, for example mental health or screening programmes. The GPs also arranged an education programme to be included in these meetings so GPs had an opportunity to update their continuing professional development (CPD). In addition the practice manager, a qualified nurse had set up a nurse network where nurses from the area were invited to meetings to share ideas and complete practical training.

We saw evidence that a GP telephoned a care home every Friday to see if they had any concerns that required attention before the weekend. The home provided feedback to us, stating that a GP visited at least once a week, had a walk around to see any patient who required attention, and involved patients in their care planning.

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, walk in centre and accident and emergency (A&E) department to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals.

All the electronic information needed to plan and deliver care and treatment was stored securely but was accessible to the relevant staff. This included care and risk assessments, care plans, case notes and test results. The system enabled staff to access up to date information quickly and enabled them to communicate this information when making an urgent referral to relevant services outside the practice.

We saw there was a system in place to inform the out of hours if a patient was receiving palliative care and may need to be seen out of hours. This ensured that the out of hours service knew about the patient's progress, preferences, and current needs.

Consent to care and treatment

Patients we spoke with told us that they were communicated with appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment. The CQC comments cards we reviewed did not highlight any issues with consent.

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. Awareness sessions had been provided to staff during one of their regular meetings. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

The staff we spoke with were very well aware of the Gillick competencies and how they should be applied. The Gillick competencies help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. The practice had a Gillick competencies checklist that staff to refer to if they were unsure about the process to follow. GPs and nurses told us it was not unusual for young people under the age of 16 to attend appointments alone. They told us that if they were unsure of a child's understanding of their condition or treatment they were referred to Parallel Young Person's Health Centre, a health and wellbeing service designed by and for young people under 19 years based in Bolton town centre.

Staff told us that at times they were unsure patients understood them as a high percentage of patients did not speak English as their first language. They said if they were unsure they always used the telephone translation service or involved that NESP support worker. Staff told us that on occasions relatives attended to act as an interpreter for the patient. They told us they made a judgement about whether this was in the best interest of the patient or not and always made sure the patient, not the family member, understood the issue. We were given examples of parents bringing their children for childhood immunisations and nursing staff not being sure the parents understood the procedure or what the vaccination was for. In these cases they always arranged for an interpreter, either face to face or over the telephone.

The practice routinely gave longer appointments to patients with learning disabilities or mental health needs.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

We saw evidence that the practice engaged with patients at various stages of their lives to prevent ill health or identify it at an early stage. Patients were invited to 'over 40s' health checks where patients between the ages of 40 and 70 were targeted. These checks included some checks, such as blood pressure, with blood being tested if it was thought appropriate. A lifestyle discussion took place and there the chance of developing a long term condition was identified advice was given and their health monitored. A health trainer attended the practice every week specifically to carry out these checks. Patients over the age of 75 were also routinely invited for a health check.

All new patients were invited for a check-up with a nurse, with a GP being involved if appropriate. We saw that where a patients did not attend any of the health checks they were invited to they were contacted, by someone who spoke their language if necessary, to make another appointment.

The non English speaking patient (NESP) support worker contacted patients who did not speak English as their first language or were from other cultures and did not understand the NHS system, They explained about health promotion and used a holistic approach. For example, they also made sure patients were informed about dental health. Through regular auditing the practice were able to evidence that there had been an increased take-up rate for cervical smears and childhood vaccinations.

Care plans were in place for patients who were at an increased risk of an unplanned hospital admission. The practice was ahead of its 2% target. We saw the care plans were monitored on a spreadsheet, where it was easy to identify when they needed to be reviewed. The risk of falls was assessed for these patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We received 33 CQC comments cards telling us what patients thought of the practice. All of these contained positive comments. Several patients commented that they were treated in a dignified way by friendly staff. Patients commented that the reception staff were very kind and said they were able to ask a nurse for help if it was required.

We spoke with six patients during our inspection. The majority of patients we spoke with did not speak English as their first language. However, no concerns were raised relating to the dignity, compassion and empathy shown to patients.

We reviewed the results of the most recent national GP survey, that had a response rate of 17%. These showed that in some aspects the practice scored lower than other practices in the clinical commissioning group (CCG) area. These areas included patients being treated with care and concern by the GP, and the GP involving patients in decisions about their care. However, this information was not reflective of what we found during our inspection. The survey showed that 86% of patients thought the nurses were good at listening to them, and 82% of patients thought the nurses treated them with care and concern. These were both above the CCG average, which was 80% and 79% respectively.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk. There was a private room available if patients wished to have a confidential discussion with a receptionist, and a sign in the reception area informed patients of this.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

All the CQC comments cards we reviewed spoke positively of the practice. Patients commented that GPs and other staff spent time with them and listened to their concerns. They said staff at the practice were caring. Although the majority of patients we spoke with did not speak English as their first language they indicated they were involved in their care planning.

We saw evidence that a GP visited one of the care homes in the area at least once a week. As part of their visit they assessed and spoke with patients who had a care plan in place to minimise their risk of an unplanned hospital admission. This group of patients who would not usually visit the practice were therefore involved in decisions about their care and treatment.

The practice ran a weekly drop in clinic at the nearby university. This had started off as a way to meet the sexual health needs of students but audits showed mental health needs were often being identified. Where this occurred patients were provided with additional support and signposted to the appropriate service.

A non English speaking patient (NESP) support worker often worked from the practice. The NESP scheme started in May 2014 to educate patients about accessing services, booking and cancelling appointments, educate patients on health and life-style choices, increase the uptake of childhood immunisations and smear tests and encourage patients to access English classes. We spoke with the NESP support worker who told us the practice was integral in setting up the scheme, which was currently run bit the CCG. They told us that the practice had a lot of information for patients available in different languages. However, they had found that often patients could speak a language but were not able to read it. The NESP support worker therefore met with patients in order for them to be fully involved in the planning of their care. Translation services were also available at the practice and were often used. In addition the GPs could speak several languages.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

Although there was no counsellor available at the practice patients were referred for counselling in the area if it was required. None of the patients we spoke with had required a counselling service. Patients who had suffered bereavement received a bereavement pack and information about services in the area who could help. The local Citizen's Advice Bureau (CAB) attended the practice and saw patients to give them advice.

The practice kept a carers register and were proactive in identifying carers who were patients at the practice. There was a carers notice board to give information about different support groups in the area. We also saw the carers lead at the CCG had attended the practice to deliver training to staff. Staff told us this was to help them identify carers and any difficulties they may be experiencing. They had also received training on information and support groups that were available to carers in the area.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

One GP took the lead for the majority of conditions, such as diabetes, asthma and women's health. There was a system in place to ensure patients with long term conditions had regular appointments to review and monitor their condition. Also medicine reviews were arranged at appropriate interval for patients who required regular medicines.

The practice kept a register of patients with a learning disability. They were invited for an annual health check and were contacted by telephone if they did not attend. Where appropriate and the practice had consent to do so, they contact the patient's carer when arranging for a review of their condition. This avoided some appointments not being attended. When a patient was invited for a mental health review this was a joint review with a GP and a nurse practitioner. Their medicines and care plans were reviewed at the same time and clinicians followed a robust template so any further health needs could be identified. This removed the need for multiple appointments. The same procedure was followed for patients with Dementia.

All patients over the age of 75 were given a named GP. We saw that over 75s health checks were arranged by a nurse. Care plans were in place for patients who were at an increased risk of hospital admission. The practice had exceeded their target for putting care plans in place and we saw evidence all patients who would benefit from a care plan had one in place. The care plans were well thought out and clear. We saw they were working documents that were regularly updated and were not perceived as a paper exercise. We saw that as well as preventing hospital admission these care plans helped identify areas where the practice could help patients.

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

We saw evidence that the practice regularly engaged with the CCG looking at ways their practice could improve. The practice population was diverse and the practice had been instrumental in setting up a new service with the CCG for non-English speaking patients (NESP). A NESP support worker worked from the practice. We spoke with them and they explained they worked with families and individuals who did not speak English as their first language or did not understand the role of the NHS. The information and audits we saw showed that by addressing the needs of this group of people inappropriate accident and emergency (A&E) attendances had decreased, as had the number of GP appointments where patients did not attend. In addition, more patients were attending for procedures such as cervical smears and the childhood vaccination rate had increased. The NESP support worker told us that as well as being able to explain the importance of procedures they could reassure patients about issues such as whether vaccines contained ingredients that may be against their religious beliefs.

We saw the practice had an active patient participation group (PPG) that met regularly. The practice listened to the views of the PPG members and made changes where appropriate. A recent example was the way in which appointments could be booked.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. They were aware of the number of travellers, homeless patients and patients from black and minority ethnic (BME) communities. The GP told us approximately 85% of their patients were from a BME background, with approximately 50% of these not speaking English as their first language.

The practice had access to a telephone translation service that was used regularly. The NESP support worker who was based at the practice was also able to translate for patients if required and the GPs spoke several languages.

The practice had a website that gave comprehensive information about appointments. The website had the facility to translate each page into many different languages to meet the diverse needs of the population. Information at the practice was also available in different languages.

All staff had completed equality and diversity training. The practice was spacious and there was ramped access for patients who used a wheelchair. All the consultation rooms except one were accessible to wheelchairs. There was limited parking at the practice but there were dedicated parking for patients with mobility difficulties.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Appointments were available from 8am until 6.30pm Tuesday to Friday and from 8am until 8pm on Mondays. Plans were in place to start having appointments on Saturdays. When the practice was closed patients were advised to contact a registered out of hours provider. Routine appointments could be booked up to four weeks in advance. When a patient asked for an emergency appointment they were seen on the day of their request where possible. On occasions when there were no appointments available an advanced nurse practitioner telephoned the patient to assess their need. If an appointment was required that day a GP would see the patient. It was unusual for a patient to have to wait longer than 48 hours for an appointment. When a parent asked for an appointment for a young child they were always given one the same day.

The practice manager told us most patients preferred to book at the time they required an appointment, rather than advance, and they arranged their appointment system to manage these demands. At 11.30am on the day of our inspection we checked what appointments were available. There were emergency appointments available for the same day and the first routine appointment was available in two working days.

Longer appointments were available when required. These included patients with learning disabilities. When the telephone translation service was required a double length appointment was always made. Appointments for children were available outside school hours and GPs made home visits to patients who were housebound or who struggled to attend the practice.

The patients we spoke with told us they were able to access appointments at the time they needed them. The CQC comments cards we reviewed also gave examples of patients being given appointments when they requested them. None of the comments expressed dissatisfaction with the appointments system.

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. The practice manager took the lead in dealing with complaints with a GP overseeing this.

We saw the up to date complaints policy and saw evidence it was being followed. The policy stated that verbal complaints were only recorded if they could not be resolved by the end of the following day. However, in practice we saw most were being recorded so information was available if patients later decided to make a formal complaint.

All the staff we spoke with were aware of the complaints system and knew how to support and advise patients. Information was available at the practice about how patients could make comments or complaints.

We looked at the complaints that had been made at the practice. We saw they had been dealt according to the policy and within an appropriate timescale. The practice had a report that analysed complaints and recorded where learning had been achieved following a complaint being made. This also ensured any themes were identified. Complaints were discussed in an open manner during practice meetings and all learning was disseminated to appropriate staff. Learning was also shared with GPs and nurses from other practices.

Are services well-led?

Outstanding ☆

(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 their diverse population of patients. We found details of the vision and practice values were part of the practice's strategy. GPs and the practice manager met regularly with the Clinical Commissioning Group (CCG) to discuss current performance issues and how to adapt the service to meet the demands of local people. The GPs were committed to providing a high quality service to patients in a fair an open manner.

The staff we spoke with, both clinical and administrative, all knew the values of the practice. Their regular practice meetings provided evidence that as a practice they strived to improve the service they provided

There was a well-established leadership structure with clear allocation of responsibilities amongst the GPs and the practice team. The team was extremely coordinated and we saw each team member was respected in their role. One of the partners was working reduced hours as they neared retirement. There was a succession plan in place to ensure there would not be a detrimental effect on patients or other staff when this happened.

Governance arrangements

There were defined lines of responsibility and accountability for the clinical and non-clinical staff. The practice held regular staff practice meetings. GP, managers, and practice meetings were help approximately every month. We looked at the minutes of recent meetings. These provided evidence that performance, quality and risks had been discussed and any required actions were monitored.

The GPs arranged meetings with GPs from other practices. We saw they used these meetings to discuss significant events so that all practices in the area could learn from each other. The practice manager had arranged similar meetings for practice nurses in the area so that ideas could be shared and training completed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a voluntary scheme that financially rewards practices for the provision of quality care to drive further improvements in the delivery of clinical care. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes. The practice had a very diverse patient population and regular discussed how to meet the needs of all their patients as the diversity grew.

The practice had a system in place for completing clinical audit cycles. These were quality improvement processes seeking to improve patient care and outcomes through the systematic review of patient care and the implementation of change. The clinical audits we saw provided evidence of them having a positive impact on patient outcomes.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, usually on a monthly basis. 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 reviewed the minutes from meetings and saw discussions taking place openly, with staff being encouraged to question and contribute.

The practice manager was responsible for human resource policies and procedures. The policies we reviewed were up to date, with the practice manager being aware of when updates were required. We saw that the practice had over-arching policies covering all aspects of the practice. However, the practice manager had created smaller 'overview' policies that were more easily accessible to staff. These gave relevant information and directed staff to the full policy if more in-depth information was required. The staff we spoke with confirmed they had access to these policies. They also said they were able to approach the practice manager or GPs if they had any queries.

Seeking and acting on feedback from patients, public and staff

The practice had an active patient participation group (PPG) that met approximately every three months. The PPG was representative of the patient population in terms of age, gender, ethnicity and working status. The PPG discussed areas of the practice that could be improved. They had recently given their views on the booking of appointments and opening hours, and changes were brought in or considered as appropriate. We saw the minutes of previous meetings. These provided evidence that the PPG were involved in suggesting and discussing improvements to the practice. We saw the schedule of meetings that had been planned for the following year.

Are services well-led?

Outstanding ☆

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

The practice had carried out a patient survey during 2014. The results had been discussed with the PPG and an action plan had been put in place for areas where improvement was suggested. We saw that the website had been changed to make it more accessible to all patient groups, and notices had been put up in the waiting area to communicate what appointments were offered. We saw meetings minutes that provided evidence of a further survey being carried out during 2015 to check patients were happy with the changes made and other aspects of the practice.

The practice had started to carry out the NHS Friends and Family Test two weeks prior to our inspection. This asked patients if they were satisfied with the practice and if they would recommend it. In two weeks 48 patients had responded and 92% of respondents were either 'extremely likely' or 'likely' to recommend the practice.

The views of staff were sought at the monthly practice meetings. Staff told us there was an open culture at the practice and they felt able to make suggestions at any time.

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 a selection of staff files. We saw that the practice regularly arranged training for staff who were encouraged to expand their roles. They were supported in their learning, and staff gave examples of them attending external courses, including at the university. Mandatory training was monitored by the practice manager and we saw it was up to date.

The practice manager set up the first nurse practitioner forum for Bolton, so nurses from other practices could meet up, share ideas and complete practical training such as immunisations, treating long term conditions and helping patients to stop smoking. Community nurses were also invited to meetings and we saw the practice had a large education room where these meetings were held. The GPs also arranged meetings for all GPs in the area where they could share areas of good practice and learn from significant events.

The practice had recruited apprentices and trained them through recognised training providers. Some staff worked with local schools and held dummy interviews with pupils to help prepare them for the workplace. The practice was a training practice and student doctors and nurses were often placed at the practice. We saw there was very positive feedback from the university and from the students.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example, one significant event concerned a difficulty following an operation at a local hospital. We saw the practice worked with the hospital and CCG to find a way to make improvements and these were then discussed with practice staff and the GPs and nurses who attended other meetings held at the practice.