Tillingham 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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Tillingham Medical Centre on 10 March 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 older people, people with long-term conditions, families and young children, working age people, people whose circumstances made them vulnerable and those suffering from poor mental health.

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, including recruitment checks.
- 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.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should;

Summary of findings

- Review their monitoring of medicines to ensure they are not stored beyond their expiry date.
- Improve the recording of checks and actions taken to promote patient safety. This includes meetings regarding safety incidents, cleaning arrangements and environmental checks.

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 at team meetings and informally. Minutes of meetings were not being routinely recorded to evidence learning and appropriate action had been taken. 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. Medicines were managed safely and systems in place in the dispensary were robust. Staff had been trained to manage emergencies and medicines and equipment were readily available and fit for use.

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 and used it routinely. Patient's 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 highly. 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. Staff treated patients with kindness and respect, and maintained confidentiality. Support was available at the practice and externally for those suffering bereavement or that had caring responsibilities for others.

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 provided services that met their needs. Patients said they found it easy to make an appointment with a named GP with urgent appointments available the same day. The practice had good facilities and was well

Summary of findings

equipped to treat patients and meet their 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 was being shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had clear aims and objectives and all staff worked towards them as part of a team. Staff were clear about the vision and their responsibilities. 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, although minutes were not recorded. 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. 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. Patients who were frail were monitored to reduce the risk of hospital admissions and visited in their homes by a GP. Monthly meetings took place with other healthcare professionals to identify care requirements. Patients in two care homes received regular visits from a GP. Patients suffering from dementia or nearing the end of their lives received support. Each patient over 75 had a named GP and could see a GP of their choice whenever available. Home visits and telephone consultations were available for those housebound or too ill to attend the practice. Vaccination programmes were readily available to help keep patients healthy.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Patients were monitored and their healthcare needs reviewed regularly through routine appointments or by attending specialist sessions with trained staff. 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. For those patients with the most complex needs, the practice worked with relevant health and care professionals to deliver a multidisciplinary package of care. Patients were signposted to external organisations that provided support. A system was in place to recall patients to the practice to monitor their conditions. Patients with palliative care needs were regularly monitored and relatives and carers involved in the planning of their treatment. Routine health checks were available for patients.

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 children vulnerable to abuse. Staff had received safeguarding training. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as

Summary of findings

individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. Partnership working with community midwives and health visitors took place regularly.

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 to ensure these were accessible, flexible and offered continuity of care. Early morning appointments were available for those patients who had work commitments. A full range of health promotion and screening was available for patients.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients who had a learning disability. Health checks were carried out annually or sooner if required and longer appointments were available for them. The practice undertook health assessments for patients with a learning disability who lived at a local care home. Patients were signposted to external organisations that provided support. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. 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). Patients were identified and their health monitored. People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the management of people experiencing poor mental health, including those with dementia. Patients at risk of developing dementia were offered health checks to enable early identification of the condition and to discuss treatment. The practice signposted patients experiencing poor mental health to various support groups and voluntary organisations including MIND and SANE. Staff had

received training in the care for people with mental health needs and dementia. Patients with dementia and their relatives were supported by the practice to understand the care and treatment required.	

Summary of findings

What people who use the service say

Prior to our inspection, patients were invited to complete comment cards about their views of the practice. We collected 17 cards that had been left for us and reviewed the comments made.

All of the comment cards we viewed contained complimentary comments about the GP, nurse, reception staff and the services provided. Patients commented that staff generally were kind, caring and supportive. They said that appointments could be easily obtained, explanations about treatment were clear and that staff did not make them feel rushed. They found the practice clean and hygienic and the quality of care was excellent.

We spoke with six patients on the day of our inspection. They told us that they were satisfied with the GP, the nurse and other staff working at the practice. Patients told us that they were treated with dignity and respect and that clinical staff gave them the time they needed at consultations. We were told that appointments were always available, patients were rarely kept waiting and could see a GP of their choice wherever possible. They told us that explanations about their care and treatment were clear and they felt involved in decisions about it.

The NHS Friends and Family test had recently been carried out by the practice. This reflected that patients were either extremely likely or likely to recommend the practice.

Areas for improvement

Action the service SHOULD take to improve

- Review their monitoring of medicines to ensure they are not stored beyond their expiry date.
- Improve the recording of checks and actions taken to promote patient safety. This includes meetings regarding safety incidents, cleaning arrangements and environmental checks.

Tillingham Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector accompanied by a GP specialist advisor.

Background to Tillingham Medical Centre

Tillingham Medical Centre is situated in Southminster, Essex. The practice is one of 48 GP practices in the Mid Essex Clinical Commissioning Group (CCG) area. The practice has a general medical services (GMS) contract with the NHS. There are approximately 2700 patients registered there. They are a dispensing practice.

The practice has two GP partners, only one of whom works at the practice. The practice also employs a salaried GP. Between them they cover various surgeries throughout the week. There are two nurses working at the practice, one being a nurse practitioner. The dispensary is staffed by a manager and a dispensing assistant. There is a small team of reception and administration staff.

The practice is open for appointments from 7.40am to 6pm on Mondays and Thursdays and from 7.40am to 4pm on Tuesdays, Wednesdays and Fridays. Surgeries starting at 740am are for patients who work office hours or for school children so they could access services before they travelled to work/school. The practice is closed at weekends. The dispensary is open during surgery hours.

The practice has opted out of providing 'out of hours' services to their own patients. If emergency medical help is required patients call the main practice telephone number and they are directed to an out of hour's service. Otherwise non-urgent medical advice is available using the 111 system.

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.

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

How we carried out this inspection

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

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

Detailed findings

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)

These questions therefore formed the framework for the areas we looked at during the inspection.

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew.

We then carried out an announced visit on 10 March 2015. During our visit we spoke with a range of staff including two GPs, two nurses, the practice manager, dispensary and reception staff. We also spoke with six patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the policies, protocols and other documents used at the practice. Before we visited we provided comment cards for patients to complete about their experiences at the practice and we viewed them afterwards.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included responding to national patient safety and medicines alerts, the analysis of significant events and the investigation of complaints. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses and this was encouraged at the practice.

Alerts from the National Patient Safety Agency and the Medicines and Healthcare Products Regulatory Agency were received at the practice and reviewed by one of the GPs where clinical decisions were made. This often meant identifying those patients affected by the alert and reviewing their treatment or medicines. These were recorded on the patient's record and acted on in a timely manner.

We reviewed significant event records and complaints and could see that they had been investigated appropriately to identify safety concerns. We found that safety issues were discussed at management and team meetings but minutes were not recorded. It was evident however that there was a positive reporting culture and that the practice had managed safety concerns consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for identifying, recording and analysing safety incidents. Staff, including receptionists, administrators and nursing staff, knew how to report a concern and there were forms available for that purpose. Staff spoken with told us that they were encouraged to raise issues if they identified them.

Significant events and complaints that had taken place were recorded, investigated, analysed and learning identified. Where necessary appropriate explanations and apologies were offered to patients. We looked at the records of three significant events that had taken place in the last 12 months and found that they had been dealt with effectively and learning identified.

Learning that had been identified from such incidents was cascaded to staff informally but this was not recorded. Staff spoken with were aware of them and we were assured that the learning was being shared amongst staff. Formal team meetings rarely took place and minutes were not recorded. This meant that the practice did not have an effective audit trail to evidence that learning had been discussed with staff or their ideas sought for improvement. If actions had been identified, such as a new procedure or a change of system, it was not clear that it had taken place and completed in a timely manner. The practice acknowledged this as an improvement area and told us they would formalise the meetings structure, including minute taking, in the near future.

Reliable safety systems and processes including safeguarding

The practice had a nominated lead for safeguarding and this was one of the GPs. They had received appropriate training to enable them to carry out the role.

The practice had systems to manage and review risks to vulnerable children, young people and adults, including highlighting vulnerable patients on the practice's electronic records.

We looked at training records which showed that all staff had received relevant role specific training on safeguarding. 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.

Staff spoken with were aware of whistleblowing procedures and felt they could raise any issue with the GPs or practice manager and that it would be dealt with effectively. They were also aware of who to contact outside of the practice if there was a concern that they felt they could not raise with staff at the practice.

There was a chaperone policy readily available for staff to read. 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 practice had decided that clinical staff would undertake chaperone duties for patients receiving a more intimate examination and reception staff would be used for the more routine consultations. Chaperone signs indicating their availability were visible in the reception area. All nursing staff had been

trained to be a chaperone. Reception staff had received some awareness training. Staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Patients expecting test results could call the practice during the week at a set time. The practice had a system in place for identifying those patients who had not called for a result and where the test was abnormal. This included blood and cervical smear tests. Patients would receive a telephone call, followed up by three further letters if they did not make contact. This system had identified a patient at risk where the practice established that a test result had not been received and that it required a follow-up. They were contacted and the follow-up took place.

Medicines management

We checked medicines stored in the treatment rooms and medicine fridges 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 and fridge temperatures were recorded routinely.

Medicines received at the practice that required storage in a fridge were dealt with on arrival so they remained out of the fridge for as little time as possible. The practice followed their cold chain policy for this purpose and staff were required to complete a form indicating that it had been followed after a delivery had been received. Fridge temperatures were monitored daily and records had been kept.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines for clinical use, such as immunisations, were checked and were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

As the practice was a dispensing practice we looked at the systems in place to ensure they were safe. We found that a dispensary manager had been appointed who was responsible for managing the medicines. Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. We looked at the systems in place for the receipt, storage and disposal of controlled drugs and found that they were following relevant guidance. Controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

The dispensary room used for the storage of medicines was monitored to ensure that the temperature was between the recommended ranges to maintain the effectiveness of the medicines. The temperatures of the fridge, also in the dispensary, were monitored and records were being kept.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If prescriptions were not signed before medicines were dispensed, these were referred back to one of the GPs for signature. Any medicine queries were recorded in a note book and brought to the attention of one of the GPs.

When preparing medicines for patients, there was a system of double checking used to ensure that mistakes were kept to an absolute minimum. This included checking that the prescription had been signed by a GP and that reviews of medicines were not overdue. If staff were distracted during the preparation of medicines they were required to start again to ensure the correct medicines were dispensed. When they were complete they were then checked by the dispensing manager to ensure they had been prepared correctly.

A system was in place to review medicines prescribed to patients to ensure they were still required and/or effective. This involved some patients being seen personally and conducting blood tests. The practice electronic patient record system was used to highlight when these reviews were due. Where patients failed to attend for a review they were contacted to remind them. We were told that almost all patients attended when requested.

Patients collecting medicines had their identity checked before handing them over to them and they were also advised of any side effects they may have.

Any dispensing errors were recorded and investigated to identify learning from them. There was a standard

operating procedure in place and this was being reviewed annually to ensure it was fit for purpose. Audits also took place annually and where areas for improvement had been identified, these were actioned.

Where it was established that prescriptions had not been collected a system was in place to review the reasons for the prescription by looking at the patient record. This identified where patients might be at risk of deteriorating health because they had not collected vital medicines. These were then followed up to ensure the patient was safe and well. Reviews also took place to check whether patients were using their medicines as advised to ascertain whether they were taking too few, too many or stock piling them. Appropriate advice and guidance was then given to patients.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

Not all patients used the dispensary and some used other local chemists. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. They had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

Cleanliness and infection control

The practice had a lead for infection control who had undertaken training to enable them to carry out the role. All staff had role specific infection control training. An infection control policy was in place and available for staff to refer to if required.

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice was following the guidance relating to the control of substances hazardous to health (COSHH). The quality of the cleaning was monitored by the practice manager.

The most recent infection control audit identified areas for improvement and these had been actioned. This audit had identified the need for more robust procedures to be in place including checklists for staff to follow and complete. We found that checklists were being maintained.

Minor surgical procedures took place in a treatment room at the practice. The nurse told us that surfaces were cleaned in between patients to reduce the risk of a healthcare related infection. This included cleaning all work surfaces, the trolley and couch used by the patients.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had undertaken a risk assessment for the management, testing and investigation of legionella (a term for a particular bacteria which can contaminate water systems in buildings and can be harmful).

Clinical waste was stored safely and disposed of in line with guidance and an external contractor was employed for that purpose. Clinical staff had received inoculations against Hepatitis B and they received periodic blood tests to ensure it remained effective. Non-clinical staff were offered inoculations by the practice.

Equipment

Staff we spoke with told us they had the appropriate equipment and in sufficient quantities to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all electrical and medical equipment was tested, calibrated and maintained regularly and records that we viewed confirmed this to be the case. The last portable electrical equipment (PAT) test took place in March 2015.

Equipment in use included weighing scales, spirometers, blood pressure measuring devices and a blood/sugar testing monitor. Also available for patients was a blood pressure monitoring device which was kept in the waiting room and patients were encouraged to use it.

Good

Are services safe?

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. This including ensuring that appropriate recruitment checks had been undertaken prior to employment, including proof of identification, references, qualifications and registration with the appropriate professional body.

The practice also had a policy that made clear their procedures in relation to undertaking Disclosure and Barring Service (DBS) checks. These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice policy was that all staff were required to go through this process regardless of whether they were employed in a clinical or non-clinical role.

We looked at several staff records and found that two recently employed members of staff had not been asked to supply written references. We were told however that the practice had sought verbal references from a previous employer (GP surgery) that was known to them and from one of the GPs currently working at the practice. These verbal references confirmed that they were competent to carry out the receptionist roles for which they had applied. We noted that both staff members had undergone an induction process to familiarise them with the way the practice worked.

The practice occasionally used locum GPs and nurses and these were obtained through a local agency. Where possible preferred locums were requested, but where this was not possible references, skills and experience were checked to ensure they were suitably qualified to carry out the role required of them.

The practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Where there were identified staff shortages members of staff, including nursing and administrative staff, covered each other's absence.

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.

Monitoring safety and responding to risk

The practice had undertaken a health and safety risk assessment as required by current legislation. This highlighted the risks to patients and staff at the practice and the steps to take to reduce those risks. We were told that the practice conducted an environmental check of the building regularly but this had not been recorded. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice reviewed patients' prescriptions using a system known as the dispensing review of the use of medicines (DRUMS). This involved a qualified member of the dispensary staff checking the patients' understanding of their medicines, and their ability to obtain and use them. They are intended to complement not replace the clinical medication review that was also carried out by the GPs at the practice.

Dispensary staff monitored those patients who did not collect their prescriptions to ensure that this did not adversely affect their health. They were then contacted to ensure they were well. They also monitored the prescribing of medicines to ensure patients had been taking them as instructed.

Patients who were frail or elderly were monitored and care and treatment planned to avoid unnecessary hospital admissions.

Arrangements to deal with emergencies and major incidents

The GPs at the practice used an emergency bag which they took with them when away from the practice. We checked the contents of these bags and found that they contained recommended emergency medicines. One medicine item and some syringes had gone beyond their expiry date by a month in one of the bags.

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. Processes were also in place to check whether emergency medicines were within their expiry

Good

Are services safe?

date and suitable for use. All the medicines we checked were in date and fit for use, except for one ampoule of medicine used for the treatment of anaphylaxis (a sudden allergic reaction that can result in rapid collapse and death if not treated).

We discussed the monitoring of the expiry dates of all emergency medicines with the practice on the day of the inspection and they have since contacted us to confirm that they have implemented more robust processes for checking the expiry dates of all medicines used at the practice.

The practice had arrangements in place to manage emergencies. Records showed that there were sufficient numbers of staff that had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. 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.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice employed a nurse practitioner who was qualified to provide diagnostic consultations for patients with minor illnesses and injuries. They were also able to prescribe certain medicines without the need to refer the patient to a GP. This meant that patients with the more complex needs had an increased opportunity to see a GP. The nurse also undertook child immunisations and cervical smear testing.

We discussed the practice's performance for antibiotic prescribing with the partner GP. Data available to us from the local CCG reflected that the practice's performance was comparable to similar practices. We found that the prescribing rate of some anti-inflammatory medicines was lower than the local average so we explored this further. The practice was aware of this data and our discussions with them reflected they had systems in place to ensure that these medicines were used in-line with current guidelines and best practice. We were assured that despite prescribing rates being lower than other local practices for this type of medicine, patients' needs were being met.

The practice dispensary worked with an outside organisation to review their prescribing to achieve value for money. This identified whether the practice was using the most cost effective medicines. The practice had a system in place to assess the quality of the dispensing process and was part of the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. Regular liaison took place and the practice was informed when a more cost effective version of a particular medicine was available and they were able to change their ordering process accordingly.

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 used the quality and outcomes framework (QOF) to monitor performance across key areas of healthcare. (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).

A member of staff had recently been employed at the practice whose main responsibility was QOF monitoring to ensure the practice was achieving their targets. A management meeting took place weekly where the current performance was discussed and this highlighted where the practice was achieving and where improvements could be made.

The practice was aware of their performance to the end of March 2014 and that it required improvement in some areas. In the short time that the new member of staff had been in post the practice had seen improvements in performance. These included improved coding of patient records to better identify those patients requiring closer monitoring of their health conditions in line with the targets set by QOF.

An example of an improvement in the outcome for patients was in relation to monitoring blood pressure for those suffering with diabetes. The data for last year reflected that the blood pressure readings for patients with this condition were below the area average. Since performance monitoring had improved, the practice had seen these statistics rise from 76.5% to 87.4% and this represented an improved outcome for those patients whose blood pressure was now at more acceptable levels.

The practice was about to change to a new computerised record system and at the time of our inspection they were organising training for their staff. We were told that the system currently in use did not allow for easy performance monitoring and that the new system would enable them to make further improvements.

Good

Are services effective?

(for example, treatment is effective)

The practice was aware of the patients registered with them who suffered from diabetes. They had monitored these patients and found that their treatment was not as effective as it could have been due to the way they used their insulin and the effect it had on their blood/sugar readings.

A nurse at the practice specialised in diabetes and was responsible for monitoring those patients with the condition, including their blood/sugar levels, blood pressure and adjusting their medicine/insulin. Patients with the condition had been identified and were contacted and requested to attend for regular reviews. This included children. Patients were invited to complete a questionnaire to give the nurse an overall view about the way they managed their diabetes. This included their lifestyle, diet and exercise. We were told that gradual improvements had been noticed in the health of their patients, evidenced by improved blood/sugar and blood pressure readings. Further monitoring of outcomes will continue in the future.

The practice monitored their patients suffering with asthma. Patients attended for regular monitoring and advice and guidance given to help them manage their condition and to improve their health.

Patients with learning disabilities had a health review either three monthly, six monthly or annually depending on need. For those patients who were residents in local care homes, we were told by the practice that a care plan was in place for the care home to follow.

The practice undertook blood testing for patients on warfarin medicine to ensure they were within the safe therapeutic range. Warfarin is a blood thinner used to prevent heart attacks, strokes and blood clots in veins and arteries. The practice had conducted an audit on these patients and found that 80% of them were within the recommended range.

General blood test results were reviewed by a GP each day and those requiring action were sent to the nurse practitioner for action. Time was allocated for this purpose to ensure these were carried out.

The practice had a palliative care register for those patients that required end of life care. Regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families took place, although the practice told us that district nurse resources did not always allow this to be as regular as they would have liked. They described a good relationship with Macmillan nurses, the hospice nurse and consultants.

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. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff training met the needs of patients and that it was being monitored.

GPs were up to date with their yearly continuing professional development requirements and either had 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).

Staff spoken with felt supported by the GPs and practice manager. They commented that their training needs were identified and they were encouraged to develop in their role. One example of this was a member of staff who had been sponsored to do a foundation degree relevant to nursing, on a day release learning scheme.

Staff told us that they received an annual appraisal from their line manager and said that it was meaningful. They were encouraged to complete a form prior to the appraisal interview to highlight their performance throughout the year and to identify any learning and/or development needs they might have. They told us their performance was graded and objectives set for them for the forthcoming year. They felt these objectives were linked to the overall aims and objectives of the practice. Staff told us that the practice was very positive in making available additional training for them.

Good

Are services effective?

(for example, treatment is effective)

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. Those with extended roles such as the nurse practitioner were able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. These were reviewed by a GP and then appropriate clinical decisions were made and recorded, then the patient records were updated by support staff.

The practice visited three care homes in the locality and was responsible for providing primary medical services to those persons residing there. We spoke to one of the managers of the care homes who told us that a close working relationship had developed between the home and the practice. We were told that the practice provided support for patients requiring end of life care and for those suffering with dementia.

Most consultations required the GP visiting the care homes to see patients. In particular it was highlighted that the GP provided support for relatives of those with dementia especially in relation to helping the patient understand the care and treatment required. It was evident from our contact with this care home that the practice provided effective care and treatment to those patients living there and that they were very supportive.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record.

Information sharing

The practice used an electronic patient record system to coordinate, document and manage patients' care. All staff were trained on the system but the practice accepted that it had limitations and were in the process of upgrading to a more efficient system. Staff training on the new system had been planned in advance and was due to begin shortly.

Patients were supported to use the select a hospital/ specialist of their choice when there was a need to refer them for specialist treatment. This preference was then sent to a central referral point where the most appropriate clinical pathway was selected and the patient advised of the date of their appointment. Patients usually received the date of their appointment within two weeks of the referral. We were told that referrals were dealt with on the same day and that there was no backlog.

The practice received information from the local GP out-of hour's service when their patients had cause to use it. The record of the consultation was then placed on their electronic system and reviewed by the GP to assess whether a follow-up appointment was required.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. 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.

There was a consent policy for staff to refer to that explained the different types of consent that could be given. For example, for all minor surgical procedures, the completion of a consent form was required. This covered the understanding of the procedure and any risks involved with it. A consent form had also been introduced for parents/guardians to consent to their children receiving childhood immunisations.

Staff were aware of the different types of consent, including implied, verbal and written. Nursing staff administering vaccinations to children were careful to ensure that the person attending with a child was either the parent or guardian and had the legal capacity to consent. Where there was doubt the procedure was delayed until the consent issue could be clarified.

Clinical and reception staff were aware of Gillick competence. This is where in some circumstances a child under the age of 16 can consent to receiving care and treatment without a parent/guardian being present. Where a child of this age was seen by a GP or nurse they were aware of the Gillick competence test, used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Good

Are services effective?

(for example, treatment is effective)

Clinical staff told us that patients with a learning disability and those with dementia were supported to make decisions through the use of care plans and with support from relatives and carers.

Health promotion and prevention

The practice held monthly multidisciplinary meetings with external healthcare professionals to discuss those patients identified at risk of their health deteriorating rapidly. They had identified patients who were at risk of an unplanned hospital admission and their care was discussed so this risk could be reduced. This involved considering their care and treatment needs and monitoring them. This was a recent initiative and one meeting had been held. Minutes had been recorded.

It was practice policy to offer a health check to all new patients registering with the practice. Any health concerns detected were followed up in a timely way. Smoking cessation, dietary and alcohol consumption advice was available to patients.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. The practice identified the patients eligible for this check and wrote to them advising them of the service. Health checks were also available for the elderly and for patients with a learning disability. Patients over 75 years of age had a named GP so they could receive continuity of care.

The practice offered a full range of immunisations for children. The practice was aware of those children eligible and was pro-active in achieving the national targets. Data available to us for the year ending March 2014 reflected that in some areas of child immunisation the practice was below the local average and in other areas were above. They were aware of their performance and were taking steps to improve. They had put in place a system to follow-up and contact patients who did not attend for their immunisation.

Flu vaccinations were also available for the elderly and for those patients with certain health conditions where it was recommended, such as patients with diabetes. The practice was performing in line with the national average for flu vaccinations for patients over the age of 65.

The practice also monitored patients due for cervical smear tests. Patients were sent a letter centrally advising them that they should be tested and the practice were also informed. Patients failing to book appointments were contacted three times by letter by the practice to try and encourage them to attend. If they still did not attend further attempts were made either by phone or when attending the practice for other matters. Patient records were marked up accordingly so that they could be easily identified when they attended the practice. Data held by us reflected that for the year end March 2014, the practice was in line with other practices nationally for cervical screening uptake by patients.

Patients with diabetes could attend for reviews of their condition with a nurse who specialised in their care. They received lifestyle advice and guidance to enable them to manage their condition and live a healthy lifestyle.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with six patients on the day of our inspection. They told us that staff were kind and caring and treated them with dignity and respect. Patients said their children were also well treated and spoken to in a way they understood.

During our inspection we found that reception staff were polite and courteous both in person with patients and when speaking with them on the telephone.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 17 completed cards and all of them were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

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

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.

We reviewed the most recent data available for the practice on patient satisfaction from the national patient survey from July 2014. This reflected that 92% of patients felt that the GPs treated them with care and concern and 96% said the same of the nurses at the practice.

Care planning and involvement in decisions about care and treatment

The patient survey data we reviewed from the national GP patient survey in July 2014 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Of the patients responding to the questionnaire 89% said that the GP was good at listening to them, 94% said that the GP was good at explaining tests and treatments to them and 92% said the GP was good at involving them in the decisions about their treatment.

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 supported these views.

Patient/carer support to cope emotionally with care and treatment

Staff told us that if families had suffered bereavement they were offered support and signposted to external support organisations. They could also see the GP or nurse if they felt they needed to.

The practice identified those persons with caring responsibilities and was aware of their needs. These included parents of children with cerebral palsy, patients who were disabled and families who were foster carers. Information was available in the patient waiting room and on the practice website about support groups and organisations that could help carers. The practice's computer system alerted GPs if a patient was also a carer.

The practice had subscribed to the enhanced service to reduce hospital admissions for their vulnerable patients. This included advising carers of the support that was available including the availability of additional carers if they became ill.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice was responsible for the care of patients at three local care homes. These patients were mainly elderly or suffering from dementia and one of the care homes was for patients with learning disabilities.

We spoke with one of the care homes and they told us that there was a very positive relationship between the practice and the care home. The service the practice provided was effective and met the needs of the patients. Regular attendance by one of the GPs took place and if there was an urgent matter the practice always responded in a timely manner. Patients at the care home received regular health checks and support, including medicines being supplied when required.

The practice monitored patients who were elderly and those considered to be frail and at risk of an unplanned hospital admission. The target for this service was 2% of the patient population but the practice had identified additional numbers that required support and there were currently monitoring 2.6% of patients requiring this type of support. They were identified through patient records and recorded in a register and then their health was monitored. One of the GPs and a nurse at the practice had taken the lead role in this service and this involved visiting all of the patients on the register in their own homes. This required a restructuring of their appointment system to effectively meet their needs.

Each patient was assessed and asked to complete a form about them in order to accurately identify their healthcare needs. Multidisciplinary meetings then followed with the GP, nurse, community matron and social worked to design an individualised care plan for each patient. A new local initiative was put in place to improve communication amongst the different agencies involved in this care for the elderly involving weekly teleconference calls and improved multidisciplinary team meetings. The practice had since reviewed A&E admissions for this group of patients and identified a theme that indicated that falls caused a high percentage of these admissions. This resulted in more emphasis on referrals to the local falls prevention team in order to further reduce the risk of an unplanned hospital admission.

The practice monitored patients with long-term conditions such as chronic pulmonary obstructive disorder (the name for a collection of lung diseases, including chronic bronchitis and emphysema), diabetes and asthma. Regular health checks were available for them which included lifestyle advice to support them to manage their condition.

The nursing team provided advice on smoking cessation, diet and exercise, alcohol consumption and cervical smear testing. There was also a wound care specialist nurse and spirometry (a spirometer measures lung function including the volume and speed of air that can be exhaled and inhaled and is a method of assessing lung function) testing took place for those patients with asthma.

The practice benefited from a qualified nurse practitioner who was able to undertake consultations for patients suffering from minor illnesses. This allowed the GPs to concentrate on the more complex cases. They were also a qualified prescriber so could issue prescriptions. Any health matter that required a more qualified review was referred to one of the GPs.

Patients could obtain their test results on two days of the week in the afternoons and could speak with a nurse if they wished. A system was in place to contact patients who had not called to obtain them if an adverse result had been received that required additional clinical input.

Patients receiving their prescriptions from the on-site dispensary received an explanation about the medicines and the best way to take them. This included the elderly receiving them in dosette boxes that made it easier to see when a medicine had been taken and also other support aids such as eye drop dispensers. Prescription advice was also available in braille for the blind or those with impaired vision.

Patients we spoke with and comment cards we viewed reflected that the GPs and nurses always had time to listen to their concerns and they were not rushed. They told us they were listened to and that consultations were effective with care and treatment explained in a way they understood.

Good

Are services responsive to people's needs?

(for example, to feedback?)

At the time of our inspection the practice did not have a patient participation group (PPG) but there were plans to form one in the near future. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

Tackling inequity and promoting equality

The premises and services had been adapted to meet the needs of patients with disabilities. The reception, waiting room area and consultation rooms were spacious and could accommodate wheelchair users and those with limited mobility and there was easy access to the consultation rooms. A ramp was available at the premises for ease of access.

The practice had access to online and telephone translation services but there had not been a requirement to use them. The practice welcomed patients who were travellers or who were homeless but at the time of our inspection none were registered there.

Access to the service

Appointments were available from 7.40am to 6pm on Mondays and Thursdays and from 7.40am to 4pm on Tuesdays, Wednesdays and Fridays. The surgeries starting at 7.40am were particularly useful to patients with work commitments and for families with children at school and we were told they were popular with patients. There were two bookable appointments daily for the early surgeries. Between 8am and 8.45am each day an open surgery was available and this did not require an appointment to be booked. The practice was closed at weekends. The practice also had their own dispensary and this was open during normal surgery hours.

Patients spoken with and CQC comment cards reviewed reflected that patients were satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice.

Data from the national GP patient survey from July 2014 reflected that all patients who responded found it easy to get through to the practice by phone, 99% described their experience of obtaining an appointment was good and 87% usually got to see their GP of choice. These statistics were considerably higher that the local average compared with other practices in the area.

The practice information leaflet, available in reception, explained the appointment system to patients.

Information was also available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The practice operated a duty GP system with two other practices in the locality for urgent health issues, during the hours of 1pm and 6.30pm. Each practice supplied a duty GP on a rota basis and patients could book appointments.

The practice employed a nurse practitioner who was qualified to provide diagnostic consultations for patients with minor illnesses and injuries. This enabled the GPs to respond to patients with more complex needs.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes on a specific day each week, by a named GP and to those patients who needed a consultation.

The practice monitored the use of walk-in centres by their patients. These are often used by patients when they are unable to get an appointment with their own GP. We were told that the statistics available reflected that patients from the practice were the lowest users of the centre in the local Clinical Commissioning Group. This reflected that their appointment system was effective and patients could readily access their own GPs.

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. Details of how to make a complaint were included in the practice leaflet and on their website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients spoken with were complimentary about the practice and had no cause to make a complaint but they felt that any matter would be taken seriously and resolved to their satisfaction.

We looked at the record of complaints for the last 12 months and found that only one had been received. This had been dealt with in line with their complaints policy and learning identified. This was then passed on to staff at the practice either informally or at staff meetings but minutes had not been recorded. Relevant staff did display an awareness of the complaint that had been received.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Their aims and objectives were made clear in their statement of purpose and these included providing safe healthcare for their patients, patient involvement in decisions and competent staff. These values were evident during our inspection from meeting and talking with patients and staff.

We spoke with seven members of staff on the day of the inspection and they all knew and understood the aims and objectives of the practice and knew what their responsibilities were in relation to these. Staff told us that they were encouraged to put forward their thoughts and ideas and said that they felt involved in the vision and future of the practice.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. This included infection control, safeguarding, information governance, audits, the dispensary and performance monitoring. Staff spoken with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had undertaken a number of clinical and non-clinical audits to monitor the services they provided and we reviewed two of them.

The practice had carried out an audit in relation to the appointment system in order to assess whether it met the needs of patients. The purpose of this audit was to assess whether the level of GP availability met the demands of the practice population. This involved recording the type of appointment requested and comparing it with GP availability. This took place over a period of a month in November 2014 and was then repeated in February 2015. The result of the subsequent analysis of both audits revealed that the current system in place was effective.

We looked at another audit that had been undertaken in 2014. This involved looking at the effectiveness of infection control procedures in relation to minor surgery carried out at the practice for a period of a year. Records of patients receiving minor surgery were reviewed to ascertain whether there had been any post procedure infections as a result of the treatment. The analysis revealed that there were no patients suffering from infections. The audit did highlight a need to improve record keeping in relation to infection control and we found this had been actioned.

Other audits included those as a result of receiving national patient safety alerts where patient records were checked to ensure that were on safe medicines and another in relation to the appointment system. Each audit had an analysis, findings and conclusions and where action was required it had been taken.

The practice had a number of policies and procedures in place to govern activity and these were available to staff within the practice. They were currently being reviewed. We looked at several of these policies and procedures and found they were fit for purpose. Staff spoken with were aware of how they could access them to support them in their roles.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice up to the year end of March 2014 reflected that there was some room to improve to achieve some of the targets. The practice was aware of this and had employed a new member of staff whose responsibility was performance monitoring at the practice. We found that data for this year had improved and they were aware of the areas to focus on. Although minutes were not being recorded, we were assured that practice performance was discussed at management meetings.

Leadership, openness and transparency

The practice held a clinical meeting once a month that was attended by the GPs, nurses and practice manager. There were informal management meetings every other Friday where complaints, significant events and safety issues, amongst other things, were discussed. There were no general staff meetings although issues were discussed informally with staff. There were no minutes of meetings kept to evidence that they had taken place or that actions had been identified and actioned.

The practice told us that the meetings structure was a little ad hoc and minutes were not routinely recorded. As a small practice they shared information on an informal basis and when speaking with staff we were assured that relevant issues had been discussed with them. Due to the absence of minutes this could not be evidenced by the practice and where learning had been identified and improvements

Are services well-led?

Good

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

made there was no audit trail to confirm they had taken place. The practice recognised this as an area for improvement and was open with us about this issue and has agreed to change the way meetings are held and recorded.

Staff told us that the leadership team at the practice were open and transparent and encouraged views and ideas for improvement. They told us they were kept informed of all relevant issues affecting them, including learning from complaints and safety issues. Staff thought the practice was well-led and a nice place to work and were complimentary about the leadership in place. The practice have agreed to set up more regular team meetings and improve the recording of them to evidence that issues have been discussed with staff and that discussions have taken place where ideas can be exchanged.

Seeking and acting on feedback from patients, public and staff

The practice had recently implemented the NHS Friends and Family test for the month of January 2015. This test provides patients with the opportunity to provide feedback on their experience at the practice. It asks patients if they would recommend the services they have used and offers a range of responses. It provides a mechanism to offer both good and poor patient experience. The results indicated that a high percentage of patients would be extremely likely to recommend the practice with the remainder of patients likely to recommend it. There were no replies that reflected the practice would not be recommended.

The practice did not have a patient participation group but there were plans to start one in the near future.

Data available for the national GP patient survey from July 2014 involved patients answering a questionnaire about the services provided. Of the 248 patients sent questionnaires, 54% of them had replied. The results reflected that a high percentage of patients were satisfied with the services provided at the practice. Data reflected that patients were 100% satisfied in two particular areas and they were getting through to the surgery by phone and having confidence in the last GP they spoke with. In many other areas they achieved over 90% satisfaction rates, such as explanations about their care and treatment and confidence in the nursing staff.

The practice had sought feedback from staff either informally or at team meetings, but minutes were not recorded. Staff told us that their views were sought and they had been consulted about improvements and their ideas as to the types of services that could be in place.

Management lead through learning and improvement

The practice took part in meetings with other practices in the local area. These meetings were arranged so that joint learning could be identified that would benefit the patients at each practice. One of the GPs at the practice was the lead for the area and one of the nurses was the practice nurse forum chairperson. We were told that meetings were attended monthly and practice managers were also invited to attend. Governance, ideas for improvement and driving change in primary care were discussed and shared. Guest speakers also attended to give presentations about a range of healthcare topics to promote learning and innovative thinking in relation to the care and treatment patients received.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events, complaints and other incidents and shared with staff informally and at staff meetings.