Datchet Health Centre

Quality Report

Datchet Health Centre
4 Green Lane
Slough
Berkshire
SL3 9EX
Tel: 01753 541268
Website: www.datchetdoctor.co.uk

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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 of Datchet Health Centre, 4 Green Lane

Slough, Berkshire, SL3 9EX on 25 March 2015. This was the first inspection undertaken at the practice.

Overall the practice is rated as good. However, the practice should make some improvements to ensure consistent standards of cleanliness are achieved and review the availability on three days of the week of appointments for patients who work.

GPs and management at the practice were aware of the views of the registered patients and responded to feedback from patients. A recent survey showed that the number of patients who would recommend the practice to others had increased by 10% in one year.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- 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.
- 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. High standards were promoted and owned by all practice staff with evidence of team working across all roles.
- The practice recognised any weaknesses in the way services were delivered and implemented action to make improvements.

Summary of findings

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

The provider should::

- Ensure appropriate cleaning standards are consistently achieved. A legionella risk assessment must be put in place with relevant control measures to reduce the risk of legionella being identified.
- Further review the availability of appointments that are accessible to patients who work.
- Retain all documentation relating to pre-employment checks.
- Clarify their audit plan to formalise the number of completed audit cycles that identify and address areas of clinical performance that could be improved.

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 although there are some areas where improvements should be made. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong, reviews and investigations were thorough and lessons learned were communicated widely enough to support improvement. Risks to patients who used services were assessed, the systems and processes to address these risks were in place. The general cleaning standards achieved were inconsistent and the practice recognised these needed closer monitoring.

Are services effective?

Good

The practice is rated as good for providing effective services. Recent data showed patient outcomes were 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 for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Most patients said they found it easy to make an appointment with a GP and that urgent appointments were available the same day. However, some patients of working age told us they sometimes found it difficult to obtain appointments outside of working hours. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

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

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients were offered a structured annual review to check that their health and medication needs were being met. If the patient did not attend the practice had a follow up system to remind the patient of the importance of their review. For those people with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations and the first baby immunisations were combined with the mother and baby health checks, which meant one appointment instead of two. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working-age patients (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified but, the appointment system did not

Summary of findings

offer sufficient flexibility to offer appropriate access to this group. Appointments on three days a week were only available until 5:10pm. Extended hours were available on two mornings and two evenings a week and practice staff endeavoured to reserve these appointments for patients who worked. However, patient feedback showed that patients in this group were not always positive about accessing appointments that suited their work commitments.The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for 100% of patients with a learning disability who consented to a review. The practice provided services to over 100 patients in the traveller community. The practice responded to the needs of temporary residents in the area. Additional services were provided to patients who were disadvantaged by the floods in 2013/14.

In conjunction with the PPG the practice organised health information events. The next planned event focussed on caring for the carers of patients living with dementia and wider support for all registered carers. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). Data showed an increase in the early detection and diagnosis of dementia. All of the national quality standards for caring for people on the practice mental health register had been met. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

The results of the national patient survey carried out in 2014 showed that patients were generally positive about the services they received from Datchet Health Centre but also highlighted some areas where the practice could improve. The GPs and management at the practice were committed to taking action to improve patient perception of the service. Results from a recent survey, called the friends and family test, showed a 10% improvement in the number of patients who would recommend the service to others. Changes had been made to the appointment booking system and the number of GP appointments offered. The practice had taken this action because the 2014 national survey results showed that 55% of patients had found their experience of making an appointment as good. This was below the local average.

The national survey showed that patients gave a positive rating about the care they received. Ninety per cent said the GPs were good or very good at listening to them and 94% said the nurses were good at explaining test results. Both of these ratings were above the local average. The survey had been completed by 114 patients.

The practice patient participation group (PPG) had also completed a survey in 2014. Two hundred and thirty two patients responded to the survey. The responses identified a high level of satisfaction with the practice and some areas where the practice could improve. We saw the PPG and practice had developed an action plan to address areas for improvement. For example, the practice had introduced an additional type of booked appointment, a three day appointment, to address concerns about access to appointments.

During our inspection we spoke with 17 patients. There were no CQC comment cards completed. Patients we spoke with were very positive about the care and treatment offered by the GPs and nurses at the practice. The majority of patients also told us the reception staff demonstrated a caring and supportive attitude. Patients told us they were given advice about their care and treatment which they understood and which met their needs. They also said they always had enough time to discuss their medical concerns. We received some comments relating to difficulties in obtaining convenient appointments for patients who worked.

Areas for improvement

Action the service SHOULD take to improve

- Ensure appropriate cleaning standards are consistently achieved. A Legionella risk assessment must be put in place with relevant control measures to reduce the risk of legionella being identified.
- Further review the availability of appointments that are accessible to patients who work.
- Retain all documentation relating to pre-employment checks.
- Clarify their audit plan to formalise the number of completed audit cycles that identify and address areas of clinical performance that could be improved.

Datchet Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team was led by a CQC Inspector and a GP. The team included a second CQC inspector and an expert by experience. Experts by experience are members of the team who have received care and experienced treatment from similar services.

Background to Datchet Health Centre

Datchet Health Centre is a purpose built practice which has been located on the current site since 1984. The health centre was rebuilt in 2000 and has subsequently been extended to provide services to a larger patient population.

There are four GP partners at the practice, one salaried GP and two long term locum GPs. Three GPs are male and four female. The practice serves a patient population of approximately 10,500. The practice employs four practice nurses and a part time health care assistant (HCA). The practice manager is supported by an assistant and a team of administrative and reception staff. Services are provided via a General Medical Services (GMS) contract (GMS contracts are negotiated nationally between GP representatives and the NHS).

The practice population of patients aged between 30 and 69 is slightly higher than average and there are less than average aged under 29. The population of patients aged over 70 is similar to the local average.

Datchet Health Centre is accredited to provide training for qualified doctors who are preparing to become GPs. The practice received a visit for the accrediting body in 2014 and is approved to continue as a training practice.

The practice had not been inspected before.

Services are provided from:

Datchet Health, 4 Green Lane, Slough, Berkshire, SL3 9EX

The practice has opted out of providing out of hours services to their patients. Out of hours services are provided by East Berkshire out of hours via NHS 111. There are arrangements in place for services to be provided when the surgery is closed and these are displayed at the practice, in the practice information leaflet and on the patient website.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service on 25 March 2015 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 practice is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This practice had not been inspected before and that was why we included them.

Detailed findings

How we carried out this inspection

Prior to the inspection we contacted the Windsor, Ascot and Maidenhead Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch to seek their feedback about the service provided by Datchet Health Centre. We also spent time reviewing information that we hold about this practice including the data provided by the practice in advance of the inspection.

The inspection team carried out an announced visit on 25 March 2015. We spoke with 17 patients and 15 staff. Comment cards had been available for patients to complete for two weeks prior to our inspection. However, none had been completed.

As part of the inspection we looked at the management records, policies and procedures, and we observed how staff interacted with patients and talked with them. We interviewed a range of practice staff including GPs, nursing staff, managers and administration and reception staff.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, an incident where a patient attended for an appointment when they had advised the reception staff they had chest pains. The chest pain protocol was reinforced and all staff knew to advise the patient to call an ambulance to their home immediately and not book them for an appointment.

We reviewed safety records, incident reports and minutes of meetings where these were discussed over the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. The practice had introduced a more formal system of minuting the weekly clinical meetings and these minutes were available for all staff to review. Learning from discussions about incidents and near misses was therefore, available to all.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed the record of significant events for 2014. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held quarterly. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Significant events were recorded by the practice manager or the GPs. Staff wishing to raise a significant event did so by relaying the details to the practice manager who completed a significant event record and scheduled the review of the event by the clinical team. We reviewed the record of the eight significant events that had been reviewed and acted upon since April 2014. We saw evidence of action taken as a result. For example the system of advising all reception staff when an appointment should be cancelled to avoid inconvenience to patients. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. If the alert related to medicines there was a follow up system in place to check that action had been completed. This system was supported by the CCG visiting pharmacy advisor. Changes in medicines required from national alerts were discussed by the GPs and the pharmacy advisor at regular meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details for relevant authorities were held on a shared file on the practice computer system and staff we spoke with knew where to find these.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example patients who, if they telephoned the practice, should be put through to a GP for immediate advice and support.

There was a chaperone policy, which was visible on the waiting room noticeboards and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness

for a patient and the health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. The practice had a policy which did not require reception staff to act as chaperones. However, two members of reception staff we spoke with told us they had either completed a criminal records check or were due to apply for one. These staff had been identified for training to become chaperones and told us they would not be permitted to act as a chaperone until such time as their training was completed and criminal records checks carried out. The practice was aware of the need for chaperones to be of confirmed good character and appropriately trained to undertake the role.

Medicines management

We checked medicines kept in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. We checked a sample of 16 medicines and all were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. We found two containers of test material kept in a medicines fridge. Both were out of date. However, these could not have been used because the test materials in question had been superseded. These materials were disposed of immediately.

There were records of the practice meeting with the CCG medicines management pharmacist. These showed the practice took an active role in monitoring prescribing. Data showed the practice to be one of the best within the CCG for management of medicines. This data also showed the practice to be meeting the targets for antibiotic prescribing.

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 up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. For example, if a patient did not respond to a reminder to have a blood test taken before their next prescription was due the GPs would only issue a prescription for one week of medicine and ensure the patient attended for their blood test.

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. All blank prescriptions from printers were removed and locked in cupboards at the end of each working day.

Cleanliness and infection control

We observed the premises to be mostly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept by the cleaning staff. We found the cleaning standards were inconsistent. There was an accumulation of dirt below the examination couches in two consulting rooms. The practice had not achieved appropriate separation of cleaning equipment which meant they could not ensure that equipment used in general areas was not also used in a treatment room. This presented a low risk of cross infection and was resolved when we reported the issue to the manager. The nurse responsible for leading on infection control instituted regular meetings with the cleaning contractors. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice did not include chairs of permeable fabric in the six monthly deep cleaning programme. We found two chairs in the waiting room that were stained.

The practice had a team that led on infection control. One of the practice nurses held the lead responsibility for ensuring the practice had control measures in place to reduce the risk and spread of infection. There was evidence to show this member of staff had worked with external expert advisors in 2014 to enable them to provide advice on the practice infection control policy and carry out staff training. The external advisors had completed an infection control audit and there was an action plan arising from the audit. The practice was responding to the findings. For example a capital grant had been obtained to change taps to elbow operated design in treatment and consulting rooms.

Good

Are services safe?

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff told us they used aprons and gloves when changing a wound dressing for a patient. There was also a policy for needle stick injury and policies for clearing spillages of potentially harmful fluids.

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 did not have a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We were told that the practice had been advised they were at low risk from legionella because there was no stored cold water on site. However, there was no evidence to support the statement. The practice should hold a written legionella risk assessment that included control measures to identify, assess and manage the risk of legionella.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. However, we found one piece of office equipment which did not carry a test sticker. It was not clear whether this piece of equipment had been tested and passed safe to use. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure measuring devices.

The practice held records of essential maintenance for most other important equipment. We saw that the patient passenger lift had been serviced, the fire alarm and firefighting equipment had been serviced in early March 2015 and the gas boiler was subject to annual service and safety checks. The internal wiring in the practice had been checked when the extension was built in 2010.

Staffing and recruitment

We reviewed the staff records of eight members of staff. We found that the records for staff recruited by the current practice manager contained evidence of all appropriate recruitment checks being undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). However, some documents, for example references were not present for staff that had been recruited by previous practice managers. On the day of inspection the practice could not locate evidence of a criminal records check being completed and proof of a salaried GP being on the NHS England register. This documentation was forwarded to us within two days of the inspection. The practice should ensure that all records relating to recruitment are available within staff personnel files at all times. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was more staff on duty in the morning when the practice was at its busiest. There were arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff told us there were usually enough of them on duty to maintain the smooth running of the practice and there were always enough staff to keep patients safe.

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 checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. The health and safety policy was supported by a range of risk assessments. For example, equipment safety and manual handling. Health and safety information was available to staff.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated

Good

Are services safe?

external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment. There were logs confirming this equipment was checked regularly.

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 date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice was located close to the river Thames. The surrounding area had been subject to severe flooding during the winter of 2013/14 and the practice had a flood action plan prepared to deal with any similar flood problems in the future. One element of this plan identified the need to maintain contact with patients on vulnerable patient registers and be aware that this group of patients may require additional support from both the practice and emergency services.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. A fire warden had been appointed and was knowledgeable about their role. Appropriate notices were displayed identifying fire exit routes and emergency lighting had been installed on the premises. Staff had access to fire training via an online training package.

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), the Royal College of Nursing guidelines and from local commissioners. Local CCG protocols and guidelines were available in a file on the practice computer system. The staff we spoke with and the evidence we reviewed confirmed that GPs and nurses completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. We saw minutes of a meeting of the team that led on diabetes and this showed us the practice focussed on specific long term conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs and staff we spoke with told us support from colleagues was always available and readily given. We were given further examples of how GPs with additional expertise were able to offer advice to others. One GP held a qualification in sexual and reproductive medicine and they were able to advise colleagues in this aspect of care and treatment.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The discharge summaries of patients discharged from hospital were reviewed within two days of receipt. There were follow up arrangements in place for patients who had been admitted to hospital who were subject to care plans relating to avoiding hospital admission. These patients were contacted within three days of receipt of their discharge summary. The annual review of patients with more than one long term condition was co-ordinated to reduce the number of visits the patient had to make to the practice.

National data showed that the practice was at one stage a relatively high referrer to hospital services. The GPs had introduced a referral review system where potential non-urgent referrals were discussed. There was also a referral review service at the CCG. Data showed the practice referral rates had reduced since the referral reviews had been undertaken. All GPs we spoke with used national standards for the referral of patients with suspected cancer who needed to be seen within two weeks. There was a tracking system in place to ensure these referrals had been received and accepted by the hospital.

Discrimination was avoided when making care and treatment decisions. 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

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice presented us with eight audits that had been carried out in the previous 12 months. Four of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. One of these audits related to the carrying out of an important blood test for patients with diabetes after they had given birth. The practice identified at first audit they needed to increase the uptake of these tests and put action in place to do so. We saw the second cycle of the audit showed double the number of completed tests. This meant that more patients received an important check of their long term condition after giving birth. Other examples included audits to confirm that the GPs who undertook the fitting of contraceptive devices were doing so effectively. We noted that the practice had undertaken a series of clinical audits during the past two years. However, we did not see an audit plan and it was unclear which audits were to be completed in cycles and which were individual audits in response to specific clinical issues identified.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw their performance against local prescribing targets and had

Good

Are services effective?

(for example, treatment is effective)

improved from meeting 14 of 20 targets to achieving 18 of the 20 targets in the last year. The practice was one of the best performing for prescribing in the CCG. GPs had altered their prescribing practice, in line with local guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, approximately 98% of patients with diabetes received the full range of checks required to manage their condition. The practice met all the minimum standards for QOF in asthma, chronic obstructive pulmonary disease and supporting patients with mental health problems. This practice was not an outlier for any QOF targets.

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 asthma. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The visiting CCG medicines management pharmacist also audited action on medicines alerts and advised the GPs if any action remained outstanding. GPs told us they discussed the rationale for changing medicines with the patient before making any changes. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

The GPs had decided to refer patients requiring minor surgical procedures to a visiting surgeon. This decision had been reached to ensure consistency and safety in undertaking minor surgery. GPs worked within their sphere of competence and expertise by carrying out joint injections.

Effective staffing

Practice staffing included GPs, practice nurses, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors. For example, three held additional qualifications in obstetrics, one held a diploma in children's medicine and one in family planning and reproductive medicine. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our discussions with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, training in glycaemic control for patients with diabetes. The practice was a training practice. However the GP in training was on leave at the time of inspection. We were told that doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

Administration and reception staff completed appraisals and had personal development plans. Two members of staff had taken on additional duties in the last year having identified potential to develop their administration skills. Reception and administration staff had training plans in place including an expectation to update safeguarding training and complete training in information governance within the next two months.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles in seeing patients with long-term conditions such as asthma and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, x- ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they

were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately and there was a cover system to ensure that results for GPs who were absent from the practice were followed up by a colleague.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

The practice held multidisciplinary team meetings. Health professionals who worked with patients registered at the practice were able to attend the weekly clinical team meetings and there was a formal monthly meeting of the multidisciplinary team to discuss the needs of complex patients, for example, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, palliative care nurses and health visitors. Decisions about care planning were documented in the notes of the meeting. We also saw records of meetings held by the community care team that involved GPs from the practice and a neighbouring practice. The care of patients with complex needs was co-ordinated for the locality and not just the practice.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made approximately 85% of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice had also signed up to the electronic Summary Care Record and this was fully operational(Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). Patients were also able to access their own records via a secure system.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that 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. The practice had a checklist and protocol to support staff in their decision making when a patient may not have the capacity to understand their care and treatment. We were given examples of both GPs and staff taking additional time to ensure patients understood their treatment. Written material was used, when appropriate, to support descriptions of treatment proposed and patients were given the opportunity to take information away from the practice to consider before proceeding with treatment.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. Discussions with GPs and practice nurses showed us that there was a clear understanding of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all joint injections and for fitting of a contraceptive coil written consent was obtained. We were shown examples of the consent received for these procedures. Records showed that relevant risks, benefits and complications of the procedure were explained to patients.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

The practice had met regularly with the CCG to discuss the implications and share information about the needs of the practice population.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all of these patients were offered an annual physical health check. Practice records showed 100% of those who had consented to their health check had received it in the last year. The practice had also identified the smoking status of approximately 77% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. There was evidence that 99% of those identified as smokers had received smoking cessation advice. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support, either by GPs and nurses at the practice or by referral to local services, in line with their needs.

The practice's performance for cervical smear uptake was 80%. This met the national target of 80% and was in line with others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears. Performance for national chlamydia screening programme was above average for the CCG.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice combined the administration of the first baby immunisations with the mother and baby health check. This meant that mother and baby did not have to attend the practice twice and this had contributed to a higher uptake of first baby immunisations. Data we reviewed showed the practice was achieving over 95% uptake for all childhood immunisations. Again there was a clear policy for following up patients who did not attend.

The practice took part in the national campaigns for both bowel screening and mammography. Data we reviewed showed that the practice performed in line with other local practices in the take up of shingles immunisation with 43% of 70 year olds receiving this immunisation increasing to 65% of 80 year olds receiving the immunisation.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey conducted in 2014. This data showed 114 patients had completed the survey which was only 36% of those who had been sent the questionnaire. We also reviewed the 2014 a survey of 232 patients undertaken by the practice's patient participation group (PPG) and the results from the friends and family recommendation survey carried out by the practice between December 2014 and February 2015. The number of patients who would recommend the practice had risen by over 10% since the last national patient survey. The evidence from all sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example the practice was rated highly for satisfaction scores on consultations with doctors and nurses with 90% of practice respondents saying the GP was good at listening to them and 85% saying the GP was good at treating them with care and concern.

Patients had not completed CQC comment cards to tell us what they thought about the practice. However, we spoke with 17 patients on the day of inspection. All of the patients we spoke with told us the GPs and staff treated them with dignity and respect. Many of the patients described the service as excellent and said they would recommend the service to others. We received some less positive comments relating to access to the service and we reported these back to the practice.

We saw 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.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 82% of practice respondents said the GP involved them in care decisions and 94% felt the nurses were good at explaining treatment and results. Ninety eight per cent of respondents said they had confidence and trust in the GP they saw. The result for GPs involving patients in care decisions was below the local CCG average. However, 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.

Staff told us that translation services were available for patients who did not have English as a first language but this service was rarely used.

Patient/carer support to cope emotionally with care and treatment

GPs and nurses were aware of local groups that offered support to patients requiring emotional support. We were given examples of patients who had suffered a bereavement being referred to these groups. GPs and nurses told us how they allocated additional time to support patients who had suffered bereavement and we were given an example of a patient being offered a follow up appointment to offer further support in dealing with their loss. If the patient did not wish to visit the practice advice and support was offered over the phone.

Patients we spoke with told us they received support and advice in both understanding and coming to terms with a diagnosis of a long term condition. The PPG had worked with the practice to hold health education events that focussed on dealing with long term medical conditions.

Notices in the patient waiting room and information on the patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw the written information available for carers to ensure they understood the various avenues of support available to them.

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. For example, in providing home visits to patients from the nearby traveller community and by combining the mother and baby health checks with first baby immunisations.

We saw that the practice engaged with the clinical commissioning group (CCG). One of the GPs was the lead for two CCG initiatives. One of these was the preparation of a bid to fund extended hours on evenings and weekends. We saw minutes of meetings where CCG initiatives and priorities were discussed and actions agreed to implement service improvements. For example, meeting CCG prescribing targets.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, the practice worked with the PPG to provide educational events promoting awareness and healthy lifestyles. One of the educational events included a presentation on living with arthritis.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, patients living in care homes, travellers and patients with a learning disability. We saw that 100% of patients with a learning disability who consented to an annual review of their health had received the review in 2014/15. The practice had over 100 patients registered from the local traveller community. The needs of this group had been recognised with GPs taking more time to ensure verbal communication was used in all consultations. Patients living in three local care homes were registered with the practice. GPs supported these patients by offering visits as and when the patients required and by offering advice to the care home staff. The practice recognised the needs of carers and worked closely with their patient participation group to identify carers and ensure they received advice and support appropriate to their needs.

The practice had access to online and telephone translation services for patients who first language was not English.

The practice provided equality and diversity training through e-learning. We saw that few staff had completed this course of training. The training plan showed us there was an expectation that all staff would do so on a three yearly cycle. Training records also showed that two GPs had completed additional training on this topic.

The premises and services had been adapted to meet the needs of patient with disabilities. An induction loop system was available to assist patients using hearing aids and written information could be enlarged for patients with a visual impairment. Consulting and treatment rooms were located on both ground and first floors and there was lift access to the first floor. The practice corridors enabled access for patients who used wheelchairs and mobility scooters. This made movement around the practice easier and helped to maintain patients' independence. A number of consulting and treatment rooms were equipped with height adjustable couches which enabled patients with mobility difficulties to use them.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The waiting rooms also contained a number of chairs with higher seats to assist patients who had difficult rising from low chairs

Access to the service

The practice operated a mix of opening hours. On a Monday the practice offered the first appointment at 7:10am and did not close until 7:15pm and a further evening clinic was available on Thursday until 7.15pm. However, the practice closed at 6 on Tuesday, Wednesday and Friday with the last appointment on these days being 5:10pm. Earlier appointments were available on Wednesday morning from 7.30amd and on Friday from 8am.

A range of appointments were offered including routine, three day in advance and on the day urgent appointments. Telephone consultations were also available which were useful for patients who worked or those that found it difficult to attend the practice. The practice had appointed

Good

Are services responsive to people's needs?

(for example, to feedback?)

a nurse practitioner who was due to start work in early April (nurse practitioners are trained to a higher level than other practice nurses and are able to offer a wider range of services). The appointment of this member of staff was aimed at enhancing access to the practice for all groups of patients and reduce waiting times for appointments.

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

Longer appointments were also available for patients who needed them and those with long-term conditions. Three of the patients we spoke with told us they found the longer appointments very helpful. Patients were able to book appointments with a named GP or nurse. Home visits were made to three local care homes to patients who needed one.

Patients we spoke with were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Two patients we spoke with told us they had called on the morning of our inspection and accessed these urgent appointments.

The practice provided extended opening hours on three mornings and two evenings every week.. The two evening clinics had appointments available until 7:10pm. These were particularly useful to patients with work commitments and the practice staff endeavoured to ensure patients who worked received these appointments. We spoke with some patients who worked. They told us that they had encountered some problems in booking appointments that were convenient to them and one patient had taken the day off work to be seen. We noted that the last bookable appointment on three days of the week was at 5:10pm. This limited the access to appointments on those days to patients who worked.

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 was responsible for coordinating the handling of all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The complaints procedure was available from reception, detailed in the patient leaflet and on the patient website. Staff we spoke with were aware of their role in supporting patients to raise concerns. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 12 complaints received in the last 12 months and found that all had been addressed in a timely manner. When an apology was required this had been issued to the patient and the practice had been open in offering complainants the opportunity to meet with either the manager or one of the GPs. We saw that complaints of a serious nature were linked to significant event reviews. For example a complaint raised at the end of January was discussed by GPs and nurses as a significant event in March. This was confirmed in records of the meeting.

The practice reviewed complaints annually to detect themes or trends. The record of complaints for the last year did not identify any themes or trends. However, lessons learned from individual complaints had been acted on.

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 mission statement. This detailed how through continuing development, the Practice Team is committed to providing the highest standards of primary health care focused on the needs of all members of our community. The mission statement had been developed in 2003 and was regularly revisited at practice away days to check that it remained relevant.

We spoke with fifteen members of staff and they all knew and understood the practice core values which were to provide patients with excellent care available at the right time and place. To listen first and involve patients in all decisions made. Our observations of staff receiving patients at reception and in taking phone calls from patients demonstrated that they placed the patient first in their day to day work. Some of the patients we spoke with told us how both GPs and the reception and administration staff had created additional appointments to ensure they were seen promptly.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at five of these policies and all were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and two partners were identified as the leads for safeguarding. We spoke with fifteen members of staff and they were all clear about their own roles and responsibilities. They all told us they felt well supported and knew who to go to in the practice with any concerns. They told us that managers and GPs were accessible and listened to ideas for improving services and to any concerns they had.

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

We looked at the report from the last review of medicines management which showed that the practice had the opportunity to measure its performance in managing medicines against others and identify areas for improvement. As a consequence the practice had an action plan to meet the prescribing targets. The practice had increased the number of prescribing targets reached by 20% in one year.

The practice completed clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, the outcomes of minor surgery were reviewed every year and success rates for taking cervical smears were audited annually.

The practice was active in ensuring data and personal information was governed appropriately and staff were expected to undertake training in information governance. The practice had completed a nationally recognised audit of information governance.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly. There was a team meeting programme that varied between teams. The clinical team met once a week and the administration and reception team met approximately once every six weeks. 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 noted that there was an open invitation for other health care professionals for example, health visitors and district nurses.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies including the maternity leave policy and the confidentiality policy which were in place to support staff. There was a staff handbook that was available to all staff. Staff we spoke with knew where to find practice policies and the handbook if required.

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

The practice had gathered feedback from patients through patient surveys and complaints received. We saw that complaints, in anonymous format, were shared with the patient participation group. We looked at the results of the annual patient survey. This showed that a number of patients commented they would like to be able to book an appointment within a couple of days when they did not

Are services well-led?

Good

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

need to be seen on the day. We saw as a result of this the practice had introduced a number of three day in advance appointments. The availability of these appointments was promoted on the practice website.

The practice had an active patient participation group (PPG). This had been in existence since 2005 and a core committee of 10 patients was in place. The PPG promoted membership and sought to include representatives from various population groups. However, the PPG members we spoke with told us that recruiting younger patients to join the group had been, and continued to be, difficult to achieve. In addition to the PPG committee the practice accessed the views of a further 820 patients via an online patient reference group. The PPG had carried out annual surveys and met six times a year. We reviewed the results of the last patient survey. The questions used in the annual survey had been designed by the PPG and PPG members told us they collated the results and prepared the action plan arising from the results. The results and actions agreed from the survey were available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the policies file and electronically on any computer within the practice. Staff we spoke with were all aware of the whistleblowing policy and told us they knew where to locate it should they need to refer to it.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. The staff training plan showed us that staff were required to complete mandatory training and that nurses were supported to attend relevant professional updates. Staff we spoke with told us about their personal development plans and we saw that two members of the reception team had been identified for management development. Both had their work commitments adjusted to include administrative duties in addition to their reception role. Regular appraisals took place for all grades and disciplines of staff.

The practice was a GP training practice and had recently been re-accredited to continue to train qualified doctors wishing to become GPs. We were unable to speak with the GP in training because they were on leave at the time of the inspection.

One of the GPs at the practice took a leading role within the CCG. This role included leading on prescribing for the whole CCG and leading on working with other practices on a project to provide additional availability of GP appointments during evenings and weekends. Discussions with staff showed us that the information gained from close working with the CCG was shared and learning gained from it.

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