

Wallington 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 Wallington Medical Centre on 16 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for older people, people with long term conditions, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing 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.
- Patients' needs were assessed and care was delivered following best practice guidance.

- Staff had received training appropriate to their roles and any further training needs had been identified and planned through annual appraisal.
- Patients said they were treated with kindness, compassion, and respect and that they were involved in decisions about their care and treatment.
- Information about services and how to complain was available and easy to understand.
- Patients were generally satisfied with the appointment system and found it easy to make a convenient appointment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

- The practice had arranged an independent clinical risk self-assessment in April 2013 to identify potential risks that could impact on patient and staff safety. All

Summary of findings

clinical and non-clinical staff had actively engaged in the process and participated in identifying risks and actions required to mitigate risks. As a result improvements to practice were made, including changes to administration processes, roles and responsibilities.

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

The provider should:

- Undertake a risk assessment to assess the different responsibilities and activities of administration staff to determine if they are eligible for a Disclosure and Barring Service (DBS) check.
- Ensure that staff receive training in the use of the automated external defibrillator (AED) purchased by the practice (in accordance with the Resuscitation Council (UK) recommendations for primary care).
- Ensure that all practice policies are dated and include dates of review.

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?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There was a system for reporting and recording significant incidents and evidence that learning and improvement to services occurred as a result of these events. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. The practice had arranged an independent clinical risk assessment of the practice and had made changes to the service as a result to improve safety for patients and staff. Staff had received role appropriate training in safeguarding vulnerable children and adults. There were enough staff to keep patients safe.

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality, for example in antibiotic prescribing and referral rates to secondary care. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and other locally agreed guidelines and used them routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. The practice offered childhood immunisations and cervical screening in line with national guidance and uptake rates were average for the Clinical Commissioning Group (CCG) area. Staff had received training appropriate to their roles. There was evidence of annual appraisals and personal development plans for all staff that included areas for future training. The practice held monthly multi-disciplinary team meetings attended by district nurses, health visitors and palliative care team when appropriate.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated with kindness, compassion, and respect and that they were involved in decisions about their care and treatment. Feedback from the National GP Survey showed satisfaction scores for consultations with nurses were above the Clinical Commissioning Group (CCG) average. The reception area was designed to ensure patient confidentiality and patients we spoke with said their privacy and dignity was maintained by practice staff.

Good



Summary of findings

We observed staff to be kind, pleasant and helpful towards patients attending the practice and when speaking to them on the telephone. There was information available in the waiting room to signpost patients to various support organisations.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients were generally satisfied with the appointment system and found it easy to make a convenient appointment. The practice operated a new call back telephone consultation system with the duty doctor that resulted in either advice provided over the phone or a face to face appointment arranged. The practice had provided clear information to patients to help them navigate the recent change in appointment system. Same day appointments and home visits were available as need required. The practice was accessible to people with disabilities. The practice had a complaints procedure that was well advertised in the practice waiting room, practice leaflet and on the practice website. There was evidence of learning from complaints and changes to practice to improve service. Complaints were reviewed annually to identify any trends or themes.

Good



Are services well-led?

The practice is rated as good for being well-led. It had a clear vision to provide appropriate and accessible care to the local population. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings, for example incident management procedures and repeat prescribing policy. There were systems in place to monitor and improve quality and identify risk. The practice kept a record of significant events and discussed these at monthly practice meeting to identify and share learning. The practice proactively sought feedback from staff and patients, which was acted on. The patient participation group (PPG) was active and performed annual patient surveys that were reviewed and discussed with the practice to identify areas for improvement. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



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

The practice is rated as good for the care of older people. The practice used a risk stratification tool to identify vulnerable patients and developed proactive care plans for community management that were regularly reviewed. There was evidence of multi-disciplinary working to support and meet the needs of complex elderly patients in the community. Home visits were available for patients unable to attend the surgery due to illness or immobility. The practice offered seasonal flu vaccinations to patients over 65 years of age in line with national guidance.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Patients with long-term conditions were offered annual health checks with the practice nurse. The practice offered in-house spirometry for patients with Chronic Obstructive Pulmonary Disease (COPD) to facilitate diagnosis and management. Seasonal flu vaccinations were offered to patients aged over six months and less than 65 years of age in defined clinical risk groups. There were monthly multi-disciplinary team meetings attended by district nurses, health visitors and palliative care teams when appropriate, to discuss and manage the needs of patients with long-term conditions. GPs had access to advice from secondary care consultants within 48 hours via email to assist with management of patients with complex needs.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. Staff had received up to date training in safeguarding vulnerable children and aware of the signs of potential abuse. Alerts flagged up on patients electronic records if there were any on-going child safeguarding issues. The practice offered a full range of childhood immunisations and were proactive in contacting families who had not completed the immunisation program. The practice nurse offered family planning services and would refer patients to local sexual health clinics for advice and management of sexual health concerns.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). There were extended hour appointments once weekly and the option to arrange for a GP

Good



Summary of findings

call back from 8.30am to facilitate those unable to attend the practice during working hours. The practice offered NHS Health Checks to all patients aged 40 to 75 years previously diagnosed medical conditions.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice offered annual health checks to patients with learning disabilities and had access to support from the community learning disability team. The practice provided medical care to a local residential care home for patients with learning disabilities and this included visiting the home to carry out annual health checks and twice yearly seasonal flu vaccinations. There was rapid new patient registration available for the transient patient population to ensure they had access to immediate health care if required. The practice maintained a list of patients who were carers, including child carers.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Clinical staff were proactive in referring patients with a suspected diagnosis of dementia to the local dementia services and staff had attended training run by this service to raise awareness of the condition. Patients experiencing poor mental health were invited to annual health checks. One of the GPs attended quarterly community mental health team meetings to discuss and manage care plans of patients with complex needs. Patients suffering with depression were offered extended appointment slots to ensure enough time to discuss issues and concerns.

Good



Summary of findings

What people who use the service say

During our inspection we received 29 Care Quality Commission (CQC) comment cards that patients had completed and spoke with five patients who used the service. Overall the feedback given was positive. The majority of patients were satisfied with the care they received and felt that all staff at the practice were helpful, respectful and caring. This was similar to the findings of the national GP patient survey published in January 2015

that found that 84% of respondents described their overall experience of the practice as good and 71% said that they would recommend the practice to someone new to the surgery. Eighty per cent of respondents described their experience of making an appointment as good. All CQC comment cards received were complimentary and there were no suggestions for improvement.

Areas for improvement

Action the service **SHOULD** take to improve

- Undertake a risk assessment to assess the different responsibilities and activities of administration staff to determine if they are eligible for a Disclosure and Barring Service (DBS) check.
- Ensure that staff receive training in the use of the automated external defibrillator (AED) purchased by the practice (in accordance with the Resuscitation Council (UK) recommendations for primary care.
- Ensure that all practice policies are dated and include dates of review.

Outstanding practice

- The practice had arranged an independent clinical risk self-assessment in April 2013 to identify potential risks that could impact on patient and staff safety. All clinical and non-clinical staff had actively engaged in the process and participated in identifying risks and actions required to mitigate risks. As a result improvements to practice were made, including changes to administration processes, roles and responsibilities.

Wallington Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, practice manager and expert by experience who were granted the same authority to enter the practice premises as the CQC inspector.

Background to Wallington Medical Centre

Wallington Medical Centre is a well-established GP practice located within the London Borough of Sutton and is part of the NHS Sutton Clinical Commissioning Group (CCG) which is made up of 27 GP practices. The practice provides primary medical services to approximately 2,400 patients. The age range of patients is predominately 15 – 49 years and the number of five – 24 year olds is greater than the England average. The practice population deprivation score is higher than the England average and there is a high incidence of unemployment.

The practice holds a Personal Medical Services (PMS) contract. (PMS is one of the three contracting routes that have been available to enable commissioning of primary medical services).

The practice team comprises of one male senior GP partner, one male GP partner and one female salaried GP. There is one part-time female practice nurse who is supported by a healthcare assistant. The managerial and administration team include a practice manager, office supervisor and three receptionists. The practice is an accredited GP training practice and hosts one female trainee GP registrar and a foundation year two doctor.

The practice opening hours are 8.00am to 7.30pm Monday, 8.00am to 6.30pm Tuesday, Wednesday and Friday and 8.00am to 1.30pm Thursday. Appointments are available in the mornings from 9.00 am to 11.50 am Monday to Friday, and in the afternoon from 3.00pm to 6.10pm Tuesday, Wednesday and Friday with extended appointment times from 6.30pm to 7.15pm on Monday. The practice has opted out of providing out of hours services and have arranged with an alternative provider to provide cover when the practice is closed. The details of the out-of-hours service provider are communicated on the practice website and a recorded telephone message directs patients to contact 111 NHS advice line when the practice is closed. The practice provides a wide range of services including checks for diabetes, blood pressure checks, asthma review and child health care. The practice also provides health promotion services including a flu vaccination programme, family planning and cervical screening.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

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

How we carried out this inspection

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

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

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

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

- People experiencing poor mental health (including people with dementia)

Before visiting we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We met with NHS England, NHS Sutton Clinical Commissioning Group (CCG) and Healthwatch Sutton and reviewed the information they provided us with. We looked at the practice website for details of the staff employed and the services provided.

We carried out an announced inspection on 16th January 2015.

During our visit we spoke with a range of staff including GPs, practice manager, practice nurses, reception and administration staff. We also spoke with five patients who used the service. We looked around the building, checked storage of records, operational practices and emergency arrangements. We reviewed policies and procedures, practice maintenance records, infection control audits, clinical audits, significant events records, staff recruitment and training records, meeting minutes and complaints. We observed how staff greeted and spoke with patients attending appointments and when telephoning the surgery. We reviewed 29 Care Quality Commission (CQC) comment cards completed by patients who attended the practice in the days before our visit.

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, a recent incident was reported when a sick note certificate issued had the incorrect name on it. The clinician involved corrected this when it was reported and agreed an action plan to receive training on issuing electronic sick note certificates to prevent errors occurring in the future.

We reviewed safety records, incident reports and minutes of meetings where these had been discussed for the last year. This showed the practice had managed these consistently in accordance with their incident management procedure and so could evidence a safe track record over this period of time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There was an incident management procedure document available for staff to access on the practice shared drive. There were records of significant events that had occurred during the year and we were able to review these. Significant events were a standing item on the monthly practice team meeting agenda and there was an annual significant events review of all recorded events from the last year. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used significant event forms on the practice intranet and sent completed forms to the practice manager or senior GP. All completed significant incident forms were also submitted to the Clinical Commissioning Group (CCG) for review. We were shown the system used to manage and monitor incidents. We reviewed 10 incidents and saw records were completed in a comprehensive manner according to the incident management procedure. We saw evidence of action taken as a result, for example due to incomplete communication with the practice team

following a patient death, at the next practice meeting, staff created and agreed a standard protocol to follow. 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 email 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. For example, a recent alert shared with clinical staff was about minimising the risk of prescription fraud. We were also told that safety alerts were discussed at the monthly practice team meeting to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

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, for example GPs received training to level three, the practice nurse to level two and administration staff to level one. Training was updated every three years and had last been completed in April 2013. Staff we spoke 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.

One of the GP partners was the lead for safeguarding vulnerable adults and children. All staff we spoke with were aware who the lead was 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 children subject to a child protection plan. There were monthly multi-disciplinary team meetings attended by members of the community health visitor team where any safeguarding cases would be discussed.

There was a chaperone policy, which was available for staff on the shared drive and visible to patients on signs in the consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure).

Are services safe?

Clinical staff, who were familiar with the process, were asked to act as a chaperone if required and they all had received Disclosure and Barring Service (DBS) checks. We were told that administration staff had not been Disclosure and Barring Services checked but were not required to act as a chaperone as female clinical staff were available for this role.

Medicines management

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

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

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, the practice performed regular audit on hypnotic medication prescribing within the practice.

The practice nurse used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw signed sets of up-to-date PGDs and evidence that the practice nurse had received appropriate training to administer vaccines.

The practice had a repeat prescribing policy that staff followed. Requests for repeat prescriptions were written except if a patient was housebound then telephone requests could be made. Repeat prescriptions were generated by administration staff using the electronic prescribing system, unless the patient was due a medication review or if there was a medication query. All prescriptions were reviewed and signed by a GP before they were given to the patient. Repeat prescriptions were available for collection within 48 hours of the request. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. There was a cleaning schedule for cleaning equipment in consultation rooms, such as examination couches and work surfaces, and this detailed who was responsible and how frequently they should be cleaned. Cleaning audits were carried out quarterly and we saw results from the last two audits that showed above 97% compliance with cleaning standards. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice nurse was the lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that infection control audits were completed annually. The last audit had been carried out by an external company, in September 2014 and this found 97% compliance. Action plans from the audit included arranging Legionella testing which had been completed and organising occupational health checks for staff which the practice was in the process of arranging.

An infection control and decontamination policy were available for staff to refer to, however, we noted that these were not dated. Equipment was available to help staff implement infection control measures, for example personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and there was a blood spillage kit in the cleaning cupboard. There was a policy for needle stick injury available on the practice shared drive and staff knew the procedure to follow in the event of an injury. There was a sharps management procedure available for staff to help reduce the risk of needle stick injury. All clinical staff were up to date with required occupational health Hepatitis B vaccinations.

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 a policy for the management, testing and investigation of legionella (a

Are services safe?

bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice had recently completed a Legionella risk assessment and were awaiting the results.

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. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment and this was next due in March 2015 for example weighing scales, blood pressure measuring devices and the refrigerator used to store vaccines and medicines.

Staffing and recruitment

The practice had a recruitment policy that set out the standards to be followed when recruiting clinical and non-clinical staff. There were separate policies detailing the procedures to follow when new staff started for requesting references, confirming qualifications and vetting and barring checks. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). We noted that DBS checks had not been undertaken for administrative staff as they were not required to perform chaperone duties.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

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 confirmed that actual staffing levels and skill mix were in line with planned staffing requirements.

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. The practice had arranged an independent

clinical risk self-assessment in April 2013 to identify potential areas of risk and to put strategies in place to mitigate risk and improve the safety of the service. We saw that the assessment covered several specific areas of risk including confidentiality, consent, equipment, infection control, prescribing and referrals and had included the engagement of the whole practice team in identifying risks and solutions. For example, the risk assessment identified that the system of reviewing test results from secondary care was unsafe as there was no system in place to ensure all patient test results had been received and that some normal results were posted without a review by a clinician. As a consequence the practice implemented a new test results policy that included an audit of samples sent and received to ensure all results expected had been returned to the practice. In addition all test results were now reviewed by a clinician as standard practice. Similarly the review advised updating the practice's repeat prescription policy and improving infection control procedures, both of which had been addressed immediately following the risk assessment.

The practice had a health and safety policy with a health and safety checklist completed annually. Health and safety information was displayed for staff to see. Fire alarms were checked monthly and fire extinguisher checked annually and we saw evidence that these had been completed according to this schedule.

Identified risks were included on a risk register and incident book. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk.

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 in July 2014. Emergency equipment was available including medical oxygen. The practice had purchased an automated external defibrillator (AED - used to attempt to restart a person's heart in an emergency) for which they were awaiting delivery.

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 anaphylaxis, hypoglycaemia, infection, breathing difficulties, pain, seizures and morphine overdose. Processes were also in place to check whether emergency medicines were within their expiry

Are services safe?

date and suitable for use. All the medicines we checked were in date and fit for use. The practice had an emergency telephone call handling protocol that advised staff how to respond to a patient requesting urgent medical attention.

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 failure of IT systems, disruption to electricity and water supply, loss of medical records and unplanned sickness. The document also contained relevant contact details for staff to refer to in the event of system or utility failures.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and practice nurse 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 locally agreed guidelines. We saw minutes of six clinical meetings during the last year where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. Staff told us the practice planned to introduce more frequent clinical meetings to ensure regular review of new NICE guidelines. We found from our discussions with the GPs and practice nurse that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The senior GP partner had a specialist interest in clinical areas such as diabetes, heart disease and dermatology. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

We were shown data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice used computerised tools to identify the vulnerable 2% of the patient population and developed multi-disciplinary care plans documented in their case notes that were reviewed and updated every three months. These patients were given a contact number for direct access with a clinician between 8.30am to 6.30pm should they have any deterioration in their health.

Local data showed that the practice was below the CCG average for referral rates to secondary and other community care services for all conditions. All the GPs we spoke with used national standards for the referral of for example, urgent two week referral for suspected cancers. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. The practice engaged with CCG led review of referral rates with local practices to identify any areas for improvement or change to practice.

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

Management, monitoring and improving outcomes for people

The practice showed us three clinical audits that had been undertaken in the last three years. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, the practice had completed an audit of hypnotic medication prescribing to ensure compliance with National Institute for Health and Care Excellence (NICE) guidelines. The aim of the audit was to reduce the number of patients prescribed hypnotic medicines as a first line intervention and to reduce and stop long term use where appropriate.

The first clinical audit in May 2012 identified 51 patients with long term hypnotic medicine prescribing. Each of these patient records were flagged to prompt discussion about alternative non-medical treatments when they attended the practice. A second clinical audit completed in February 2013 demonstrated 29 patients with long term hypnotic medicine prescribing and a reduction to five patients in a third audit conducted in 2015. No new patients had commenced hypnotic medicines on a long term basis during this period.

The GPs told us clinical audits were often linked to medicines management information 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, the practice performed an audit of accident and emergency attendances during surgery opening hours. As a result, patients who were identified were contacted to discuss the reason for attendance and assess if the matter could have been dealt with by the practice and if so raise awareness of the practice services and opening hours.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice met all the minimum standards for

Are services effective?

(for example, treatment is effective)

QOF in asthma, atrial fibrillation, dementia and palliative care and the majority of the standards for mental health, heart failure and stroke. The practice was not an outlier for any QOF (or other national) clinical targets. We were told the practice had identified diabetes as an area for improvement and planned to address this during 2015 by utilising their Health Care Assistant to arrange diabetic health check reviews.

The practice brought about changes to the appointment system to improve service and outcomes for patients. In 2014 they had a GP access system business case approved and funded by the CCG to change the appointment system to rapid access GP telephone triage. This meant that patients who called the practice with a clinical issue would receive a telephone consultation call back from the GP within two hours. The GP would triage the patient and determine if they needed an urgent same day appointment, home visit or advice. As a result of this new system we were told that waiting times for appointments had reduced from three to five days to same day and that patient appointment non-attendance (DNA) had reduced from 60 to 30 per month. The practice anticipated a reduction in the number of unexpected accident and emergency attendances when they reviewed the data for 2015.

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 every six to 12 months dependent upon condition. The practice repeat prescribing policy set out guidelines for GPs to refer to when performing six monthly medication reviews to ensure unnecessary medication was stopped. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that after receiving an alert, the GPs had reviewed the use of the medicine in question and where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the

area. For example, the practice was below the CCG average for referral rates to secondary services and in line with the CCG average for emergency admissions and accident and emergency attendances.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and 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 and this was confirmed by reviewing the personal development plans in administration staff files. Appraisal for clinical staff included 360 degree feedback from colleagues and their 'ability to listen' rating. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the practice nurse had recently attended an update training course on learning difficulties. The practice had a training and development policy that set out mandatory training for staff as well as the procedure to establish individual training needs through annual appraisal.

Administration staff had received training in customer service and dealing with difficult patients. As the practice was an accredited training practice, doctors who were training to be qualified as GPs were offered extended appointment times of 20 minutes whilst their confidence and skill levels grew. They also had access to a senior GP throughout the day for support. The practice had an induction pack for locum staff to review prior to working at the practice to make them aware of the practice protocols and procedures.

The Practice nurse was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and family planning.

Are services effective?

(for example, treatment is effective)

The practice had a policy for managing poor staff performance. We were told the practice had an 'open to feedback' culture and any concerns were dealt with directly by the practice manager when they arose.

Working with colleagues and other services

The practice worked with other service providers to meet and manage patient's needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries 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 that they were received. This policy was available on the shared drive for staff to refer to. All results were reviewed by the duty doctor who would action any abnormal results on the day. Patients were advised to contact the practice after three to five days for blood results. All staff we spoke with understood their roles and felt the system in place worked well. The practice had access to advice from secondary care speciality consultants via email and would receive responses to questions within 48 hours. Any changes to repeat prescription as a result of communication from secondary care could only be made by a clinician.

The practice held monthly multi-disciplinary team meetings to discuss the needs of complex needs patients. These meetings were attended by district nurses, health visitors and palliative care team when appropriate and decisions about care planning were documented in a shared care record. The practice had three monthly meetings with the CCG pharmacist to discuss prescribing issues.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a system in place to share 'Special Patient Notes' with the local out-of-hour service. Referrals were made to secondary services with referral letters typed by the referring doctor and accompanied by printed summary of the patient's medical history to ensure relevant background information was made available. The practice had processes in place to ensure referrals made were received. For example, after sending an urgent two week wait referral if the practice did not receive a confirmation receipt, administration staff

would contact the relevant department to ensure it had been received. The practice received notifications if a patient did not attend a hospital appointment and this would be discussed with the patient as required.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system 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 secondary care to be saved in the system for future reference.

Consent to care and treatment

Clinical staff were aware of the Mental Capacity Act 2005, the Children's 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. For example, the practice nurse was aware of guidance for obtaining consent from patients with learning difficulties. The practice had a Consent Protocol and Mental Capacity Act Policy available on the shared drive for staff to refer to when taking consent and assessing capacity.

Patients with a learning disability were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). The practice confirmed that 14 out of 15 care plans for patients with learning difficulties had been reviewed in conjunction with their annual health check review.

When interviewed, staff gave examples 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).

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the clinical staff to use their contact with patients to help maintain or improve mental, physical

Are services effective?

(for example, treatment is effective)

health and wellbeing. For example, offering smoking cessation advice to smokers and opportunistic cervical smears to women due screening when they attended for contraceptive review.

The practice offered NHS Health Checks to patients aged 40 to 75 years with no previously diagnosed medical conditions. The health care assistant was able to offer lifestyle and diet advice if required by patients.

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 were offered an annual physical health check. The practice had also identified the smoking status of 82% (2013/2014 data) of patients over the age of 16 and actively offered referral to pharmacy-led smoking cessation clinics.

The practice's performance for cervical smear uptake was 76% for 2013/2014, which was in line with other GP practices in the CCG area. The practice had conducted an audit of inadequate smear samples to identify areas for

improvement to the service. Inadequate smear sample numbers were low with a 2.5% rate. The practice performance for flu immunisation uptake in patients over 65 years of age was 63% which was average for the CCG area.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The uptake rate of immunisations was between 87 – 91% depending on the vaccine at 12 months, 72% – 86% at 24 months and 74 – 84% at five years. The uptake rates were better than CCG average at 12 months and at CCG average rates for 24 months and five years. Administration staff were proactive in contacting the parents of children under five years who had not been immunised and offering them the opportunity to make an appointment. Sixty-three per cent of patients aged over 65 years of age and 43% of patients aged over six months and less than 65 years of age in defined clinical risk groups, had received a seasonal flu vaccination in 2013/14, which were below the CCG average.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we observed staff to be kind, pleasant and helpful towards patients attending the practice and when speaking to them on the telephone. Patients we spoke with told us that they were treated well by the practice staff and that they were gentle, caring and respectful. All of the 29 completed Care Quality Commission (CQC) comment cards we received were complimentary and referred to staff as helpful, kind and caring.

Evidence from the latest GP national patient survey published by NHS England January 2015 (95 respondents) showed that patients were satisfied with how they were treated. Eighty-seven per cent said that the last GP they saw or spoke to was good at treating them with care and concern, 99% said the last nurse they saw or spoke to was good at treating them with care and concern and 91% found the receptionists helpful, which were above average compared to the local Clinical Commissioning Group (CCG) area.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The reception desk had glass screen with a sliding hatch that was closed to provide privacy when the receptionists were using the telephone and maintain patient confidentiality. The waiting area was bright and clean with comfortable chairs for patients.

The practice had a chaperone policy and information about chaperoning was displayed in consulting rooms. Patients had the option to see a male or female GP when booking an appointment. The practice had a communication standards document available for all staff to promote effective and clear communication with patients.

There was a visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The results of the GP national patient survey showed that patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example, 81% of respondents said the last GP they saw involved them in decisions about their care and 91% felt the GP was good at explaining treatment and results. Ninety-eight per cent said the nurse was good at listening to them and 97% said the last nurse they saw was good at involving them in decisions about their care, which was above average compared to the local Clinical Commissioning Group (CCG) area.

Patients we spoke with during our inspection told us they felt involved in decision making about the care and treatment they received. They also told us that the GPs were good listeners, explained results and treatment options well and provided sufficient information for them to make informed decisions about their care. Patient feedback on CQC comment cards we received reflected this feedback.

There were posters and information leaflets displayed in the waiting room about common conditions and serious illness providing information on symptom recognition, condition management and support organisations to help patients to be informed about their health and care.

The practice had access to a translation service for patients who did not speak English as their first language and was used to involve patients in decisions about their health care and to obtain informed consent. There was information available on the practice website in a variety of languages about the role of GP services for new patients to the practice who did not speak English as their first language.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice. CQC comment cards we received reflected this feedback. There was a wide variety of leaflets in the waiting room providing signposting information for many issues, for example cancer support, bereavement and domestic violence.

Are services caring?

The practice kept a register of patients who were carers, including those under the age of 18 years. The practice computer system alerted GPs if a patient was a carer. We saw written information available in the waiting room and on the practice website for carers to raise awareness of support available to them.

Procedures were in place for staff to follow in the event of the death of one of their patients. This included informing

other professionals, such as district nurses, who had been involved in the patient's care, so that any planned appointments, home visits or communication could be terminated in order to prevent any additional distress.

The practice maintained a list of patients receiving end of life care and this was available to the out of hour's provider. The practice had close links with the palliative care team who attended monthly multi-disciplinary meetings to discuss the needs of patients receiving end of life care.

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 NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice used a risk stratification tool to identify the top 2% of vulnerable older patients and developed care plans for these patients that were reviewed on a three monthly basis. These patients were also given a direct telephone number to one of the GPs that could be called between 8.30am to 6.30pm if they required urgent advice or input. The practice held monthly multi-disciplinary team meetings attended by the district nurses, health visitors and palliative care team when appropriate, to proactively manage complex older patients. Home visits were available for patients unable to attend the surgery due to immobility or illness and housebound patients could also request repeat prescriptions by calling the practice.

The practice performed in house spirometry for the diagnosis and management of Chronic Obstructive Pulmonary Disease (COPD). The practice offered annual review of patients with long term conditions with either the practice nurse. GPs could seek advice on management of patients with long term conditions from secondary care consultants through an email system to reduce need for referral to hospital. Patients with complex medical needs were discussed in monthly multi-disciplinary team meetings attended by district nurses, health visitors and palliative care team when appropriate, to create comprehensive care plans. We were told the new appointment system allowed dynamic appointment slots to cater for individual patient need, for example patients with newly diagnosed diabetes would be allocated extended appointment slots to allow enough time to discuss the diagnosis and management options.

We were told the practice served a high deprivation area and as a result staff worked closely with health visitors and social services to manage any child safeguarding concerns. Safeguarding alerts were flagged up to GPs on the patient's

electronic records when they attended for an appointment. The practice offered a full range of childhood immunisations in line with national guidance and had a proactive approach to calling the parents patients who had not received immunisations to arrange an appointment for them. The practice offered cervical screening in line with national guidance and the practice nurse told us they would opportunistically offer appropriate patients a smear when they attended for contraceptive review. The practice nurse had received training in family planning and GPs regularly referred patients if required to the local sexual health clinic for advice and management of sexual health concerns.

The practice offered extended hour appointments until 7.15pm on a Monday to assist patients who work or are in full time education in accessing medical care. The rapid access appointment system offers a call back with the duty doctor at a convenient time for telephone consultation meaning patients did not need to attend the practice to access health advice. The practice offered NHS Health Checks to patients aged 40 to 75 years with no previously diagnosed medical conditions.

The practice provided medical care to a local residential care home for patients with learning disabilities. Clinical staff attended the home twice a year to provide seasonal flu immunisations and perform annual health assessments for all patients. We were told the practice had a good relationship with the staff at the home and they would ring the practice for additional review of patients if required. The practice nurse had recently received update training on managing patients with learning difficulties including access to the learning disabilities team in the community for additional support. We were told that some of the practice population may be transient and they offered a rapid new patient registration process for these patients to ensure they can access immediate health care. The practice maintained a register of patients who were carers, including child carers, and an alert would flag on a patient's electronic record to inform the clinician that they were a carer and may require additional support.

The practice proactively referred patients with suspected dementia to the local dementia services for assessment. Clinical staff had recently attended lectures provided by the local dementia service to improve knowledge and understanding of the illness. We were told the practice had responded to feedback from patients with depression who

Are services responsive to people's needs?

(for example, to feedback?)

considered that there was not enough time to cover their issues and concerns during a standard appointment. In response the practice created a dynamic appointment system that allowed GPs to book extended appointments for patients experiencing poor mental health such as depression. One of the GPs attended quarterly community mental health team meetings to discuss patients with complex needs who received input from community mental health services. The practice offered annual review for patients experiencing poor mental health.

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, feedback from the 2013/2014 PPG patient survey indicated some patients wanted access to appointments or medical advice before 9am and as a result the practice offered patients call backs for telephone consultations from 8.30am if required.

Tackling inequity and promoting equality

The practice had access to translation services for patients who did not have English as their first language. The practice provided equality and diversity training for new staff. There was an equal opportunities policy available on the practice shared drive for staff to reference. The practice was on a single level with a single step at the entrance but was otherwise step free. Disabled patients who required assistance in accessing the practice could ring a doorbell, however it was noted this may be placed too high for some wheelchair users. The practice doors were not automatic to facilitate easy access for patients with disabilities; however we were told the practice had agreed funding with the CCG to install automatic doors for the entrance. The reception desk had fold down low level table to assist wheelchairs users when completing documentation.

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.

Access to the service

Appointments were available in the mornings from 9.00 am to 11.50 am Monday to Friday, and in the afternoon from 3.00pm to 6.10pm Tuesday, Wednesday and Friday with extended appointment times from 6.30pm to 7.15pm on Monday. The practice was closed from lunchtime each

Thursday. The practice had implemented a new rapid access GP appointment system from June 2014. This meant that when patients called the practice for an appointment they would receive a call back from the duty doctor within two hours. The resulting telephone consultation would lead either to advice over the phone, arrangement of a face-to-face appointment at a convenient time but usually same day, or a home visit. There were no pre-bookable advance appointments, however staff told us there was some capacity to book appointments within two days.

Comprehensive information was available to patients about appointments on the practice website and in the practice leaflet. This included how to arrange urgent appointments and home visits. We saw a specific leaflet had been created to help patients navigate the change in appointment system from June 2014. 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 about the out-of-hours service provider was provided to patients on the practice website. However we did observe that patients were directed on the practice website to NHS Direct for advice, when this service had been replaced by NHS 111.

Longer appointments were also available for patients who needed them, for example new diagnosis of diabetes or patients suffering with depression. Home visits were available for patients unable to attend the practice due to immobility or illness.

Patients were generally satisfied with the appointments system. Patients we spoke with told us they were happy with the new appointment system and that it was easy to get an appointment. This was reflected in results from the National GP patient survey published in January 2015, with 82% of respondents were able to see or speak to someone the last time they tried and 96% said the last appointment they got was convenient.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were

Are services responsive to people's needs? (for example, to feedback?)

in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system, including information on the practice website, in the practice leaflet and information displayed on a noticeboard in the waiting room. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the one complaint received in the last 12 months and found this had been managed according to the policy and in a timely manner. Learning points from the complaint and associated action plans had been documented. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

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 provide primary care services that were appropriate and accessible to the local population and consistent with local and national recognised standards and priorities. We found details of the vision were part of the practice's five year business plan. The business plan set out four principles; increasing patient services and offer commissioners better value, ensure stability and business continuity, actively engage in clinical commissioning roles and create sustainable growth plans. The practice set out yearly objectives to achieve, for example a 2013 objective was to become accredited as a training practice and that had recently been completed. Staff we spoke with understood the practice vision and knew what their responsibilities were in relation to this.

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 nine of these policies, such as incident management, infection control and repeat prescribing and saw that they were comprehensive and customised to the practice. However, we noted that some policies were not dated and did not reflect when they had last been reviewed.

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

The practice took part in Clinical Commissioning Group (CCG) led local peer review of referrals to secondary care

and accident and emergency attendances to share learning and improve performance. Data showed that the practices referral rates to secondary care were below the CCG average.

The practice had arrangements for identifying, recording and managing risks. Significant incidents were discussed at the monthly practice meeting and the practice kept a risk register to record and mitigate identified risks. The practice had undertaken an independent clinical risk self-assessment and made changes to the service to improve patient and staff safety as a result of the assessment.

The practice held monthly team meetings. We looked at minutes from these meetings and found that governance procedures, performance, and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment policy, disciplinary procedures and equal opportunities employment policy that were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through practice patient surveys, complaints, the National GP survey and comments left in the suggestion box at reception. We looked at the results of the annual patient survey and saw that some patients had requested more appointments to be made available with female GPs. We saw as a result of this the practice had increased the number of appointments for female patients with the female GPs. The practice sought views from patients about planned changes to the service. For example, the practice sent a survey to patients about additional services they were considering implementing to identify those services that patients would find most beneficial.

The practice had an active patient participation group (PPG) with six members that included representatives from various population groups, such as retired patients, patients in employment and patients of different ethnic

Are services well-led?

Good 

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

backgrounds. The PPG had carried out annual surveys and met quarterly. The practice manager showed us the analysis of the last patient survey, which was reviewed and discussed with the PPG to identify action points. The results and actions agreed from these surveys were available on the practice website. There were prominent posters in the waiting room advertising the PPG and advising prospective members how to join.

The practice had gathered feedback from staff through monthly practice team meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The practice had a whistleblowing policy and all staff we spoke were aware of this policy. Staff across the practice had actively participated in a clinical risk self-assessment conducted in 2013 in which they engaged collectively to identify risks and establish workable solutions to specific areas of practice. We saw several examples where changes to practice had been made as an outcome of decisions made through this feedback process, including changes to administration processes, roles and responsibilities.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they opportunity to attend local CCG courses. The practice was an accredited GP training practice and employed a GP registrar and foundation year two doctor.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, following a repeat prescription error made over the phone the practice had discussed the incident and agreed a policy that only written repeat prescriptions requests could be made, unless a patient was housebound.