Wardles Lane Surgery

Quality Report

(Great Wyrley Health Centre)
Dr Patel's Surgery
Wardles Lane
Great Wyrley
Walsall
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Wardles Lane Surgery on 8 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing a safe, well-led, effective, responsive and caring service. It was also rated as good for providing services for all population groups.

Our key findings were as follows;

• Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

• The majority of 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 appointment system was sensitive to the needs of the population groups and offered extended hours every Monday.

• All staff understood their responsibilities in raising concerns and reporting incidents and near misses.

• The practice linked with the Clinical Commissioning Group and other local providers to enhance services and share best practice.

• Complaints were sensitively handled and patients are kept informed of the outcome of their comments and complaints.

• Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

• The practice had a clear vision which had quality and safety as its top priority.

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

The provider should:

Summary of findings

- Ensure that fire drills are carried out and records maintained.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. Risks to patients who used services were assessed and processes and systems to address these risks were monitored and updated. The practice was situated in a local Trust building, managed locally by a health centre manager. We found that the practice held no records of completing a fire drill in the previous 12 month period. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Systems were in place to ensure all clinicians were up-to-date with both National Institute for Health and Care Excellence (NICE) and other locally agreed guidelines. The practice was using pro-active methods to improve patient outcomes and linked with other local practices to share best practice. The practice completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular reviews. Consent to treatment was always obtained where required and this was confirmed to us when we spoke with patients. The practice regularly met with other health professionals and commissioners in the local area to review local quality initiatives. Clinical audits were undertaken on a regular basis and results from those audits were used to improve the quality of services provided.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed that patients rated the practice higher than others for several aspects of care. Data also showed results that were lower than the local Clinical Commissioning Group (CCG) average which the practice was aware of and actioning. 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.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated good for providing responsive services.

We found the practice had initiated positive service improvements for their patients. The practice reviewed the needs of their local population and engaged with NHS England and the Clinical Commissioning Group (CCG) to secure service improvements where possible. Appointments were available the same day in many instances this included routine appointments. This was evidenced via their appointments system, patients we spoke with and the CQC comment cards we received and this was also verified by staff. Ninety-one percent of the survey respondents found the receptionists at the practice helpful which met with our findings from the patients we spoke with and some of the comment cards reviewed. There was a clear complaints policy and procedure demonstrating that the practice responded quickly to issues raised and brought them to resolution. There was evidence of shared learning from complaints with all staff.

Are services well-led?

Good

The practice is rated as good for providing well-led services.

The practice effectively responded to change. There was a clear set of values which were understood by staff and demonstrated in their behaviours. The team used their clinical audits, information from the national GP survey, the Friends and Family Test and staff meetings to assess how well they delivered the service and to make improvements where possible. The practice did not have a Patient Participation Group (PPG). A PPG is a group of patients registered with the practice who have an interest in ensuring the needs and interests of all patient groups are taken into consideration and to work in partnership with the surgery to improve common understanding. There was an open and honest culture and staff knew and understood the lines of escalation to report incidents, concerns, or positive discussions. All staff we spoke with felt valued for the roles and responsibilities they undertook.

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, rapid access appointments and longer appointments for those with enhanced needs. The GP carried out scheduled home visits to these patients and regular health check reviews.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. We saw that 96% of patients at the practice with diabetes had received an annual review.

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 any children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering a full range of health promotion and screening that reflected 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 those with a learning disability. It had carried out annual health checks for patients with a learning disability and all had received a follow-up. It offered longer appointments for patients with a learning disability.

The practice informed vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). All patients experiencing poor mental health had received an annual physical health check. The practice GP ensured they were kept informed of any changes in the case management of patients experiencing poor mental health, including those with dementia. The practice carried out advanced care planning for patients with dementia. The practice worked with and had access to an 'In house' memory care facilitator, who offered support to patients with dementia and their families within a more familiar practice setting.

The practice had told patients experiencing poor mental health about how to access various support groups and had literature they could make available to patients about voluntary organisations such as MIND. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with three patients during the inspection and received 36 completed CQC comments cards. The patients we spoke with said they were very happy with the service they received. They told us they experienced no difficulties getting through to the practice by telephone, access to the service was excellent and they could book an appointment the same day if required. The CQC comments cards highlighted that the practice was highly valued by patients. One patient commented they had difficulties at times getting through on the phone to make an appointment. Patients' comments were overwhelmingly positive in respect of the care, treatment and service provided by the GP. Some patient comments included suggested improvements, for example, background music in the waiting room and improved appointment availability for the female GP. Only positive comments were made about the practice, staff, care treatment and service, 33 of the 36 CQC comment cards reported the practice to be good or excellent.

Data from the national GP patient survey showed that 83% of patients who responded described their overall experience of this practice as good. The survey was sent to 277 patients and 107 replies were returned giving a 39% completion rate.

Patients did not identify any problems specifically with confidentiality at the reception desk. Patients were aware they could ask to speak to the reception staff in another room if they wanted to speak in confidence with a receptionist.

Patients we spoke with told us they were aware of chaperones being available during intimate examinations. They told us staff were helpful and treated them with dignity and respect. We were told that the GP, nurses and reception staff explained processes and procedures in great detail and were always available for follow up help and advice. They were given printed information when this was appropriate.

Areas for improvement

Action the service SHOULD take to improve

Ensure that fire drills are carried out and records are maintained.

Wardles Lane Surgery

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 and an Expert by Experience. Experts by Experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Wardles Lane Surgery

Wardles Lane Surgery is located in Great Wyrley, Walsall and is part of the NHS Cannock Chase Clinical Commissioning Group (CCG). A CCG is a group of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. The practice is located in a purpose built health centre, built in 1971.Two other GP practices and a variety of other health care professionals including District Nurses, Health Visitors, Community Midwives and Physiotherapists also occupy parts of the building. Wardles Lane Surgery total practice patient population is 1999. The practice is in an area considered as seventh less deprived when compared nationally. People living in more deprived areas tend to have greater need for health services.

The staff team currently comprises of two partner GPs, one male and one female. The male GP provides seven sessions per week and the female GP; two practice and one administration session and alternative Friday afternoon on call sessions. The practice team includes a practice manager, a practice nurse, a senior receptionist and three reception staff. Including the GPs there are eight staff in total employed either full or part time hours.

Wardles Lane Surgery opening times are Monday: 8am to 7.30pm, Tuesday to Thursday: 8am to 6.30pm and Friday: 8am to 1pm. Emergency telephone calls are responded to between 1.00pm and 2.00pm daily and Friday afternoons until 6.30pm.

The practice does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed through the out of hours service operated via the111 service.

The practice has a General Medical Services (GMS) contract with NHS England. This is a contract for the practice to deliver general medical services to the local community or communities and is a former fund holding practice.

Why we carried out this inspection

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

We carried out inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act

2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

Detailed findings

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew, for example the CCG. We carried out an announced visit on 8 April 2015. During our visit we spoke with a range of staff, a GP, practice nurse, practice manager and reception staff and spoke with three patients who used the service. We observed how patients were communicated with. We reviewed 36 CQC comment cards where patients and members of the public were invited to share their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

We reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. The practice could evidence a safe track record over time. Clinical Commissioning Groups (CCG) are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The practice had an effective system in place for reporting, recording and reviewing significant events. Records were kept of significant events that had occurred during the last 12 months and these were made available to us.

The practice manager was aware of their responsibilities to notify the Care Quality Commission about certain events. For example, if there was an occurrence that would seriously reduce the practice's ability to provide care. The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts, comments and complaints received from patients.

Learning and improvement from safety incidents

We looked at how lessons learned from significant events were extracted and shared with staff. The GP informed us that they decided which staff groups required the specific learning information from the significant events, incidents, accidents or complaints. They informed us this was to ensure timely targeted learning and development. They widened the learning and sharing to the whole staff team where it was appropriate to do so. This helped ensure the practice maintained a regime of continuous improvement. An example included an incident when written shared information was confirmed on the telephone verbally. All staff received information governance training updates and information sharing policies were revisited with staff. The whole practice team were aware of the event, action was taken immediately and learning shared with all staff.

We saw the practice had a system for managing safety alerts from external agencies. For example those from the Medicines and Healthcare products Regulatory Agency (MHRA). These were reviewed by the GP and clinical staff and action taken as required.

Reliable safety systems and processes including safeguarding

The practice had policies in place in relation to safeguarding vulnerable adults and children. These were readily accessible to staff on the practice intranet and in paper copies. Staff we spoke with confirmed their awareness of them. There was also access to local authority contact names and numbers. The GP's acted as the adult and children's safeguarding leads for the practice.

Systems were in place to highlight vulnerable patients on the practice's electronic records. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities (LD).

We saw that all clinical staff members had completed safeguarding children training to level appropriate to their role. Non-clinical staff completed level 1 training which was up to date and all staff were aware of how to recognise and safely report any safeguarding concerns.

The practice advised patients they could have a chaperone present during their consultation if they wished. We saw that staff could access the practice chaperone policy. When a chaperone was requested only staff who had received chaperone training and had either an appropriate risk assessment, or a criminal record check completed by the Disclosure and Barring Service (DBS) took on the role.

Medicines management

Systems were in place for the management of medicines. Emergency medicines for cardiac arrest, anaphylaxis (shock) and hypoglycaemia (low blood sugar) were available within the practice. We checked the emergency drug boxes and saw that medicines were stored appropriately and were in date. We saw other medicines stored within the practice were in date and robust systems to check expiry dates were implemented. Oxygen was available and stored appropriately. There were procedures to ensure expired and unwanted medicines were disposed of in line with waste regulations.

A GP at the practice told us that a pharmacist from the Clinical Commissioning Group (CCG) visited the practice on a weekly basis to provide analysis on the prescribing patterns in the practice. They commented this provided useful feedback on prescribing patterns. They regularly

reviewed national prescribing data to show whether the practice was in line with the national levels of prescribing for antibiotics and medicines known to be addictive such as hypnotics.

The medicine fridge temperatures were appropriately recorded and monitored and vaccine stocks were well managed. Vaccines were kept in a locked fridge. The fridge temperature was monitored and recorded. Staff were aware of the action to take if the temperature was not within the acceptable range. 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. Patients could access travel vaccinations other than yellow fever at the practice and staff maintained appropriate records regarding patients in receipt of vaccines.

Medicine reviews were conducted by the GP. The practice had a protocol for repeat prescribing which was in line with the General Medical Council (GMC) guidelines. The practice processed repeat prescriptions within 24 to 48 hours. Patients' confirmed requests for repeat prescriptions were dealt with in a timely way. Systems were in place for reviewing and re-authorising repeat prescriptions, providing assurance that they always reflected the patients' current clinical needs. Security measures were in place for prescriptions access in line with suggested best practice within the NHS Protect Security of Prescription Forms guidance, August 2013.

The practice checked that patients receiving repeat prescriptions had at least an annual medicine review with the GP. We found that 90% of the patients on four or more medicines eligible for a medicine review had been in receipt of a review at the time of the inspection. They also checked that all routine health checks were completed for long-term conditions such as diabetes. Written policies and procedures describing medicines management at the practice in the form of standard operating procedures were in place to help ensure consistency in practice.

The GP advised us that they took suitable precautions to prevent the loss or theft of their bag on home visits. If medicines were required they were carried in a locked carrying case and would not be left on view in a vehicle. The GPs did not log the serial numbers of the small number prescriptions taken however on home visits. The practice manager assured us that the guidance produced by NHS Protect entitled, 'Security of prescription forms guidance,' would be followed. Staff showed us that prescription serial numbers were recorded on receipt to the practice and were held securely.

Cleanliness and infection control

Infection Prevention and Control (IPC) was monitored within the practice and the policy was available to all staff. This gave information about aspects of infection control such as the handling of specimens, hand washing, and the action to be taken following exposure to blood or bodily fluids. There was an identified IPC lead, the practice nurse, who ensured all aspects of the policy were implemented fully. The lead had attended appropriate training to carry out her role. Infection control training was provided for all staff as part of their induction, and we saw evidence that the training was updated regularly.

The staff we spoke with confirmed they had received training and said any updated guidance relating to the prevention and control of infection was communicated effectively. We observed the premises to be clean and tidy and saw facilities such as hand gels, paper towels, pedal bins, and hand washing instructions to encourage hygiene were displayed in the patient toilet. We saw there were hand washing facilities in the GP surgery, nurse's treatment room and instructions about hand hygiene were displayed. Protective equipment such as gloves and aprons and goggles were readily available. Curtains around examination couches were disposable and dated. If curtains became soiled in the interim period they were changed immediately. Examination couches were washable and in good condition. Each clinical room had a sharps disposal bin. There was a record of when each bin started to be used.

There were contracted cleaners for the whole health centre building and cleaning schedules in place to make sure each area was thoroughly cleaned on a regular basis. The practice was cleaned in line with infection control guidelines and staff informed us that should the need arise, they took on the responsibility to ensure their rooms were clean.

The IPC audit was conducted by the IPC lead and information following the audit was held on file with an action plan to address any areas requiring improvement. We saw that this had been communicated widely throughout the practice team.

Good

Are services safe?

There was a documented Legionella risk assessment in place. Legionella is a term for particular bacteria which can contaminate water systems in buildings.

We found that literature to inform staff about the Control of Substances Hazardous to Health (COSHH) was available for staff to read. Cleaning products for the contract cleaners were stored in lockable cabinets in line with COSHH.

Equipment

Evidence was kept at the practice to confirm annual safety checks, such as for fire extinguishers had been completed. Portable electrical appliances and equipment calibration had been carried out by the practice. The computers in the reception and clinical rooms had a panic button system where staff could call for assistance if required. Fire alarms and extinguishers were in place. Care and treatment was provided in an environment that was well maintained. Appropriate arrangements were in place with external contractors for maintenance of the equipment and building.

Staffing and recruitment

The practice had a stable staff team with the majority of staff employed for at least four years or longer. We looked at three staff recruitment records. The sample included clinical and non-clinical staff. Records showed that there had been no recent recruits. The practice manager was aware that records should include relevant checks such as references, as well as criminal record checks by the Disclosure and Barring Service (DBS). Disclosure and Barring Service (DBS) checks are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice nurse and clinical staff had been subject to DBS checks. The practice manager had systems in place to check clinicians maintained medical indemnity insurance. The practice nurse worked part time at two different practices and their indemnity insurance was for the individual rather than the practice location. On the records seen there was evidence to show qualifications claimed had been verified, with copies held. We noted there was not always photographic proof of identity on staff files. The practice manager assured us this would be addressed including in the event a new staff member was recruited to the team.

The practice manager told us that if a locum GP joined the practice on temporary basis they would make checks to ensure their registration with the GMC was valid and check NHS England's performers list. There was no formalised system in place to verify the practice nurse registrations with the Nursing and Midwifery Council (NMC) each year to make sure they were still deemed fit to practice. However, the practice manager demonstrated that nursing staff copied them into their Nursing and Midwifery Council (NMC) registration updates which we saw were current. The practice had systems in place to routinely check the professional registration status of the GP against the General Medical Council (GMC).

Reception and administration staff were multi skilled which enabled them to cover each other in the event of planned and unplanned absence. 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 were systems in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

There were systems in place to identify and report risks within the practice. These included regular assessments and checks of clinical practice, medications, equipment and the environment. We saw evidence these checks were carried out weekly, monthly and annually where applicable. We found that the practice in general ensured the appropriate checks and risk assessments had been carried out. Fire extinguishers and alarms were checked and maintained by an external company.

Events and incidents were discussed immediately following the episode and at whole staff meetings. The practice had a system in place for reporting, recording and monitoring significant events. There were procedures in place to assess, manage and monitor risks to patient and staff safety.

The practice had procedures in place to manage expected absences, such as annual leave, and unexpected absences, such as staff sickness. There was an accident book and staff knew where this was located. Staff reported that they

always spoke to the practice manager or GP if an accident occurred. They knew where to record the information and confirmed this was shared with other staff to reduce the risk of it happening again. Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff we spoke with were clear in describing the actions they would take in the event of a patient with a long term condition requiring emergency intervention.

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 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 and records confirmed that it was checked regularly.

Emergency medicines were available in a lockable carry box within a secure central area of the practice. These were comprehensive and available to treat a wide range of medical emergencies. Examples were medicines for the treatment of cardiac arrest, anaphylaxis (allergic reaction), and hypoglycaemia (low blood sugar level). The practice had a range of age appropriate emergency medicines available. 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. When we spoke with staff we found they were aware of the business continuity plan and could readily access the hard copy. Each risk identified had 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.

Emergency equipment was readily available and included oxygen and an Automated External Defibrillator (AED). This is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Checks were undertaken to ensure they were ready for use and in date. Staff were all aware of the location of the emergency drug box and emergency equipment and secure access arrangements were in place for clinical staff members.

Fire training was completed at induction according to the practice manager. We found that some staff could not recall participating in a fire drill. Fire drills are essential in any workplace or public building for practicing what to do in the event of a fire and are a legal requirement under the Regulatory Reform (Fire Safety) Order 2005. Staff however knew what they would do in the event of a fire; the fire assembly point and the name of the designated fire marshall. The fire exits were well signposted and free from hazards to prevent escape in an emergency, there was a designated fire marshall and the fire systems had been serviced. The practice manager informed us this would be discussed with the building manager and a fire drill would be completed and where appropriate any staff fire refresher training would be arranged.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidelines from the National Institute for Health and Care Excellence and from local commissioners. We were told from regular review of treatments and prescribing, the practice was able to review medications and stabilise patients using current guidance and recommendations. We found from our discussions with the clinical staff that they completed thorough assessments of patients' needs and these were reviewed as appropriate.

Arrangements were in place to identify patients who required annual reviews of on-going care and treatment to ensure it continued to be safe and effective. We saw that the practice was appropriately identifying and reporting incidents.

There were systems in place to ensure referrals to secondary care (hospitals) were made in line with national standards. Referrals were managed primarily by using the 'choose and book' system, or when urgent, a fast track system. Staff followed up on each referral to ensure that it had been received, was progressed in a timely manner, and the result received back at the practice. Requests for home visits were recorded by the reception staff, reported to the GP and patients visited. Patients spoke with and several CQC comment cards received commented they felt they were treated in an effective and timely manner.

The GP partners showed us data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing, which was comparable to similar practices. Clinical Commissioning Groups (CCG) are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular reviews. We saw that 96% of patients at the practice with diabetes had received an annual review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

We saw evidence that patients were referred promptly for specialist advice where required promptly and with the patients' involvement and understanding. New patient health checks were carried out by the practice nurses and regular health checks and screenings were ongoing in line with national guidance.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The GP we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We saw that staff regularly reviewed elective and urgent referrals made, and that improvements to practice were shared with all clinical staff.

Discrimination was avoided when making care and treatment decisions. Interviews with the GP and staff 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

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us two clinical audits that had been undertaken in the previous year. In each of these completed audits the practice was able to demonstrate the changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved resulting since the initial audit. An example included an audit for the improvement of prescribing antiepileptic drugs (AED) in patients with epilepsy to ensure they maintained continuity of supply of a specific manufacturer's product. The practice found that The Commission on Human Medicines had reviewed adverse reactions received by the Medicines & Healthcare products Regulatory Agency (MHRA) and other publications which had reported how potential harm could occur when switching AED's in patients previously stabilised on branded products to generic products. They reviewed their

Good

Are services effective?

(for example, treatment is effective)

prescribing for all patients with epilepsy registered at the practice and three patients changed to a branded product to ensure they maintained continuity of supply. They completed a re-audit in 2014 and had found that working with the CCG pharmacist together with the local pharmacies they ensured the same branded product would be dispensed with a generic prescription to the benefit of the patients. The practice found that many of the patients on these types of medications were vulnerable adults and this audit helped to ensure they were receiving safe, high quality care. The pharmacist also ensured that carers of vulnerable adults were involved and kept informed of any changes.

The practice reviewed the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. Quality and Outcomes Framework (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 e.g. diabetes and implementing preventative measures. The results are published annually. The practice demonstrated that 90%.of patients on four or medicines had been in receipt of a medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease) and childhood immunisations. This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, staff meetings and peer support to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all GPs should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The GP confirmed that they reviewed the use of medicines for patients when alerts were received, 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 maintained a palliative care register and had regular internal as well as multidisciplinary meetings and to discuss the care and support needs of patients and their families.

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 courses such as annual basic life support. We noted a good skill mix among the doctors. The 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. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the nurse informed us that they had taken on the role of lead nurse for infection control and had received training to support her in this role.

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 A practice nurse with extended role training had been recently recruited to the practice to provide support to patients with long-term conditions such as asthma, COPD and diabetes.

The practice manager described how, where poor performance had been identified, appropriate action had been taken to manage this. Staff were provided with a staff handbook which included the practices disciplinary process.

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,

Good

Are services effective?

(for example, treatment is effective)

and letters from the local hospitals including discharge summaries and the out of hours 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.

The practice generally held multidisciplinary team meetings quarterly 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 decisions about care planning were documented. They described a good working relationship with the district nursing team and that this positive relationship and effective communication improved the monitoring and management of patients in their care. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. Patients who resided in care homes were visited by the GP either on request or as part of their medicine review or care plan reviews.

The practice is based within a health centre where Health Visitors and other community teams are based. The practice team had developed a good working relationship with the community health teams within the health centre and the Community Midwives conducted clinics every Monday for all the GP practices located within the Health Centre. The practice worked with and had access to an 'In house' memory care facilitator. They offered support to patients with dementia and their families within a more familiar practice setting.

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 referrals 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. All patients noted on the practice register as being at high risk of admission to hospital received a follow up call on discharge from hospital.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system, EMIS web, 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. Staff informed us that all scanned documents were reviewed by the GPs.

The practice communicated special patients notes information with the out of hours provider regarding patients who required specific clinical care management during the out-of-hours period, when the usual pathways of care maybe not be accessible or available. This person specific information enabled continuity of care for patients for example with a terminal illness, complex mental health concerns or those who have in place any advance care instructions such as do not attempt to resuscitate, or information that would help the attending doctor such as a medication regime.

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. The practice nurse had received specific Mental Capacity Act 2005 training in 2015. The practice had not needed to use restraint but staff were aware of the distinction between lawful and unlawful restraint. 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 some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders (DNACPR). This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. The practice scanned the DNACPR documentation onto the appropriate patient records which included the date set for this documentation to be reviewed.

The practice maintained records of the patients with a learning disability and those with dementia and used a

Good

Are services effective?

(for example, treatment is effective)

read code system to record details of their carers or people involved in supporting them. Patients were also supported to make decisions through the use of care plans, which were able, they or their family/carers or advocate were involved in agreeing. There were only a small number of patients in either of these groups and those registered at the practice were well known to staff.

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).

The GPs and nurses documented consent in the patient record as a practice policy for specific interventions. For example, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the intervention.

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 GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers.

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 they were offered an annual physical health check. Practice records showed they had received a check up in the last 12 months.

The practice's performance for cervical smear uptake was comparable to others in the CCG area. There was a policy to offer reminders for patients who did not attend for cervical smears and the practice audited their records for non-attenders.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was in line with the CCG average, and again there were clear guidelines for following up non-attenders by the practice nurse.

A register was kept of patients who were identified as being at high risk of hospital admission. Palliative care patients had up to date care plans in place. Ninety percent of patients received annual medication reviews for polypharmacy (multiple medicines). There was evidence of multidisciplinary case management meetings and provision of a named GP for patients over 75.

The practice informed us that they documented health promotion and lifestyle advice in the notes as did the GPs. We saw that the practice held a register of those in various vulnerable groups (e.g. learning disabilities). There was evidence from patients that they had been signposted to various appropriate support groups and been offered information and advice.

The practice worked with and had access to an 'In house' memory care facilitator, who offered support to patients with dementia and their families within a more familiar practice setting.

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 GP patient survey 2015. The evidence from this source showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The survey found that 87% had confidence and trust in the last GP they saw or spoke to and 67% of patients said the last GP they saw or spoke to was good at treating them with care and concern which was lower than the Clinical Commissioning Group (CCG) average of 81%. Clinical Commissioning Groups (CCG) are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. Seventy-one percent said the last GP they saw or spoke to was good at giving them enough time. The survey found that 98% of patients said the last nurse they saw or spoke to was good at giving them enough time and 99% said the last nurse they saw or spoke to was good at listening to them.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 36 completed cards and the majority were positive about the service experienced. Only positive comments were made about the practice, staff, care treatment and service, 33 of the 36 CQC comment cards reported the practice to be good or excellent. Patients said they felt the practice staff were professional, efficient, helpful and caring. The majority found staff treated them with dignity and respect. One comment was less positive in respect of the GP not being sympathetic or respectful at all times. This was not a common theme although the anonymised comment was fed back to the practice. We also spoke with three patients on the day of our inspection. The majority of patients we spoke with were happy with the care and treatment they received. We gave anonymised feedback to the practice regarding one patient's comments regarding a former issue they had raised.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

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

People whose circumstances may make them vulnerable, such as homeless patients could access the practice without fear of stigma or prejudice. However, practice staff could not recall any event when a homeless patient had needed to register at the practice.

Care planning and involvement in decisions about care and treatment

The national GP patient survey found that 59% of the practice respondents felt the GP involved them in care decisions compared to the local CCG average of 78% and 61% felt the GP was good at explaining treatment and results compared to the local CCG average of 84%. Both of these results were lower than the local CCG average. The sample sizes however were too small to draw a statistical comparison, for example only 28 patients responded to the question about the GP involving patients in care decisions.The survey was sent to 277 patients and 107 replies were returned giving a 39% completion rate.

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 they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

The practice patient list had very few patients from minority ethnic groups, 1.5% (according to NHS England's

Good

Are services caring?

National General Practice Profiles, ethnicity estimate) to which there maybe language barriers. Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The national GP patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 87% had confidence and trust in the last GP they saw or spoke to and 74% said the last GP they saw or spoke to was good at listening to them. The majority of patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information.

Notices in the patient waiting room and 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. There was written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, the practice staff contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. A sympathy card was also sent by the practice to the bereaved families. As part of the practices improvement of services for their patients, an 'In house' memory care facilitator offered support to patients with dementia and their families within the familiar practice setting.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice engaged with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. Clinical Commissioning Groups (CCG) are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. We saw minutes of locality meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population, such as the monitoring of unplanned A&E admissions.

The practice had implemented suggestions for improvements and made changes to the way it delivered services for its patients. For example, it offered early appointments from 8am and a late evening surgery once a week. The GPs took telephone consultations after morning surgery each day and also offered telephone consultation slots each day with the exception of Friday afternoon.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Examples of this included patients with a learning disability, those unemployed, and carers.

The practice had access to telephone translation services when required. The premises were accessible to wheelchair users, it had an automated door to the reception area of the practice, and consultation/treatment rooms and toilets were all on the ground floor. Patients had to request a key for the toilet facilities but when discussed with the practice manager we found that this was a health centre requirement rather than the practice's own policy. We discussed how access could be improved for example when patients were required during consultation to provide a urine sample. The practice informed us that clinical staff could gain the key from reception on the patient's behalf when requiring samples.

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.

Access to the service

Wardles Lane Surgery opening times were Monday: 8am to 7.30pm, Tuesday to Thursday: 8am to 6.30pm and Friday: 8am to 1pm. Emergency telephone calls were responded to between 1.00pm and 2.00pm daily and Friday afternoons until 6.30pm.

Comprehensive information was available to patients about appointments on the practice website. 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. This also included appointments with their named GP or nurse. Home visits were made to patients registered at the practice who resided in local care homes by a named GP, and to those patients who needed one.

The national GP survey January 2015 found that 88% of the respondents found it easy to get through to the practice by phone and 90% were able to get an appointment to see or speak to someone the last time they tried. Ninety-one percent of the survey respondents found the receptionists at the practice helpful which met with our findings from the patients we spoke with and some of the comment cards reviewed. One of the 36 patients who had completed the Care Quality Commission (CQC) comment cards told us they sometimes experienced difficulties getting through to the practice location by telephone to make an appointment The female GP worked two practice sessions per week and an evening on call surgery, some patients who chose to book appointments with the female GP may book in advance. Patients could see another doctor if there was a wait to see the doctor of their choice. We reviewed the appointments available and found that appointments were available to pre book with the female GP as well as

Good

Are services responsive to people's needs?

(for example, to feedback?)

the availability of urgent appointments. Comments received from patients showed that patients in urgent need of treatment were able to make appointments on the same day of contacting the practice.

The practice did not have a current Patient Participation Group (PPG). A Patient Participation Group (PPG) is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice had a PPG group which disbanded. The practice manager agreed to initially be involved and set up a locality PPG with other practices in the locality group. The practice informed us that this unfortunately had also disbanded. The practice was aware of its contractual obligation to set up a PPG and was working towards this objective.

We saw that the practice had a suggestions box for patients to use. We found when this was opened that no suggestions had been posted. We reviewed some completed Friends and Family Test comments the forms for which were scanned onto a folder on their IT systems. We saw that the majority of those completed said they were satisfied with the care and treatment provided by the practice.

The practice's extended opening hour on Mondays was particularly useful to patients with work commitments. For older patients and those with long-term conditions the practice offered longer appointments when needed and patients with care plans had access to a separate telephone line. Appointments were available outside of school hours for children and young people and the premises were suitable. Online booking system once registered onto the system was available and easy to use. GPs offered telephone consultations where appropriate.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system in the form of the practice summary leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at complaints received in the last 12 months and found they had been acknowledged, investigated and dealt with in a timely way following their complaints process. We saw that the practice held complaints records for a number of years and saw a folder containing records up to and including 2004. The practice reviewed complaints annually to detect themes or trends. We saw that no specific themes had been identified. However, lessons learned from individual complaints had been acted on and shared with staff to improve the practice. For example all staff received refresher information governance training following a complaint investigation and their policy reaffirmed to reduce the risk of inappropriate or miscommunication.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's informal strategy, although the practice did not have a written business plan. The practice vision and values included providing the best possible quality service for their patients within a confidential and safe local environment that was accessible to all patients.

We spoke with five members of staff and they all knew and understood the practice vision and values and knew what their responsibilities were in relation to these.

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 procedures. The policies and procedures we looked were up to date however some did not contain a date for their next review. The practice manager was aware and assured us that a system would be put in place to ensure that all policies were reviewed in line with any changes or updates made, and staff would sign to state that they had read and understood the policy updates.

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 a GP partner was the lead for safeguarding. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported, said they worked as a team 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. Quality and Outcomes Framework (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 e.g. diabetes and implementing preventative measures. The results are published annually. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at the quarterly practice meetings and action plans were produced to maintain or improve outcomes.

The practice in line with professional requirements had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

The practice held weekly partners meetings, attended locality group meetings with neighbouring practices, quarterly full practice meeting where significant events and complaints as well as organisational and management issues were reviewed and discussed. However, we found that the weekly partners meetings were not minuted. In general every three months the practice attended multi-disciplinary meetings, made up of nurses, community matron and social workers. We looked at minutes from the various meetings and found that performance, quality and risks were discussed.

Leadership, openness and transparency

We saw from minutes that whole team meetings with staff were held regularly, in general quarterly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team had events were training and education was planned and staff attended.

The practice manager and partners were responsible for human resource policies and procedures. There were a number of policies in place to support staff which included recruitment policy, disciplinary procedures and management of sickness. 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 comments, complaints, the national GP survey and the Friends and Family Test. At the time of the inspection the practice did not have a Patient Participation Group (PPG). A PPG is a group of patients registered with the practice who have an interest in ensuring the needs and interests of all patient groups are taken into consideration and to work in

Are services well-led?

Good

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

partnership with the surgery to improve common understanding. The practice manager demonstrated that results and actions were agreed from patients' feedback. For example, the extended evening service on Mondays was put in place following patient feedback. A complaint resulted in additional staff training in information governance and a compliment from a person not registered at the practice but who had been assisted by staff resulted in them donating a wheelchair to the practice.

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 manager informed us they had a whistleblowing policy which we found was available to all staff within the practice.

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 three staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff training days where guest speakers and trainers attended.

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings and away days to ensure the practice improved outcomes for patients. An example of this included hospital laboratory reporting avenues when tests were requested by a locum GP. The practice informed us that the local Trust were looking into allowing practice locum GPs access to their portal to receive test results.