Dr A R Vernon and Partners

Quality Report

Wallingford Medical Practice
Reading Road
Wallingford
Oxfordshire
OX10 9DU
Tel: 01491 835577
Website: wallingfordmedicalpractice.co.uk

Date of inspection visit: 28/01/2015
Date of publication: 16/04/2015

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 Dr AR Vernon and Partners at Wallingford Medical Practice, Reading Road, Wallingford, Oxfordshire OX10 9DU on 28 January 2015.

Overall the practice is rated as good.

Specifically, we found the practice to be good for all areas including all the population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand
- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

- The practice had an effective and efficient leadership structure which included future practice planning. All staff shared the practice objectives to deliver high quality person centred care. There was a very strong quality and educational ethos in the practice through reporting and analysis of significant events and its audit programme.

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- The patient participation group, known as the Wallingford patients in partnership (PIP) worked closely with the practice through monthly meetings. The PIP had organised a well-advertised and attended practice open day in 2014. This was now scheduled as an annual event. A representative of the PIP was recently involved in the interviews for a new GP partner.
- The practice had installed floor level wash basins to facilitate dressings changes for patients with leg and foot ulcers.

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

The provider should

- Ensure all medicines management procedures are followed consistently and the controlled drugs procedures include the disposal process.

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 report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the CCG. The practice identified 269 patients with complex needs who all had a care plan in place and priority access to a GP via a dedicated phone line. The practice had consistently achieved 100% in the clinical domain of the Quality and Outcomes Framework (QOF) since 2006 and 100% overall for the last two years. The practice was on track to achieve the same this year (2014/15). The practice had identified 531 diabetic patients and provided six monthly reviews for all its diabetic patients as they considered annual reviews to be insufficient to adequately monitor their condition. The majority of patients with long term conditions had received annual reviews of their condition: 93% of patients with chronic obstructive pulmonary disease (lung disease), 72% of patients with asthma and 100% patients with heart failure. Eighty per cent of patients with dementia had an annual review in the previous year. The practice kept a register of all patients with a learning disability and 51 out of 84 patients had an annual review of their condition so far this year and 100% last year.

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 most aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer

Summary of findings

kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

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

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority. High standards were promoted and owned by all practice staff and teams worked together to achieve these. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and it had a very active patient participation group (PPG) also known as the Wallingford patients in partnership (PIP). The PIP worked closely with the practice through monthly meetings. The PIP had organised a well-advertised and attended practice open day in 2014. This was now scheduled as an annual event. A representative of the PIP was recently involved in the interviews of a new GP partner.

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

Older people were a large part of the registered practice population. The practice considered the needs of older people in the provision of the service. For example, they had developed care plans for 269 patients with complex needs. The practice worked closely with five local nursing homes to ensure patients received consistent care from a named GP. A dispensing service for patients who lived more than one mile from a pharmacy was provided and a prescription collection and delivery service. The practice had installed floor level wash basins to facilitate dressing changings for patients with leg and foot ulcers.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medicine needs were being met.

For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice had identified 531 diabetic patients and provided six monthly reviews for all its diabetic patients as they considered annual reviews to be insufficient to adequately monitor their condition. This practice was not an outlier for any QOF (or other national) clinical targets. The majority of patients with long term conditions had received annual reviews of their condition: 93% of patients with chronic obstructive pulmonary disease (lung disease), 72% of patients with asthma and 100% patients with heart failure. Longer appointments and home visits

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were available when needed. The practice achieved 100% in the clinical domain of the quality and outcomes framework (QOF) consistently over five years and 100% across all domains for the previous two years.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. For example, children and young people who had a high number of A&E attendances. Last year's performance for child immunisations was in line with the CCG average for all age groups. Patients told us that children and young people were treated in an age-appropriate way and we saw evidence to confirm this. All children under the age of one were given an appointment the same day. Appointments were available outside of school hours.

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, for example early morning and late evening appointments were offered. The practice was proactive in providing online services as well as a full range of health promotion and screening that reflects the needs for this age group.

The practice had weekly Saturday morning surgeries to accommodate the needs of working age people. The practice also offered the convenience of a daily phlebotomy service, well woman clinic, minor conditions managements and travel immunisations.

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 people with a learning disability and all of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of

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safeguarding concerns and how to contact relevant agencies in normal working hours and out-of-hours. A dispensing service for patients who lived more than one mile from a pharmacy was provided and a prescription collection and delivery service.

A small number of patients with a learning disability and diabetes had been supported to manage their conditions. The practice nurses taught the patients' carers to administer insulin to the patients. This contributed to maintaining the patients' independence and impacted on their quality of life.

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). Ninety one per cent of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice was working towards the joint Oxfordshire dementia plan to increase awareness and improve identification of patients at risk of dementia. Eighty per cent of patients with dementia had an annual review in the previous year. GPs worked with the community mental health team to develop care plans for patients with severe mental health conditions.

The practice provided information about how to access appropriate groups and voluntary organisations.

It also provided an in-house counselling service and also referred patients to 'Talking Therapies'.

Summary of findings

What people who use the service say

The most recent national GP survey data (January 2015) for Dr AR Vernon and Partners based on 123 completed surveys (47% response), showed very good satisfaction. For example, 91% of respondents rated their overall experience of the surgery as good and 86% would recommend the surgery. The areas for improvement from the national survey were in relation to access to appointments: 50% of respondents said they found it easy to get through to this surgery by phone compared to the local average of 85% and 76% of respondents found the receptionists at this surgery helpful compared to 87%.

We spoke with 12 patients during the inspection. All the patients we spoke with were extremely positive about the care and treatment they received. They told us staff provided compassionate care. Three patients commented they had noticed an improvement in obtaining appointments in the previous few months.

We received 28 comments cards from patients. All the comments were positive and referred to the kindness and consideration of GPs, nurses and reception staff. No negative comments were recorded.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all medicines management procedures are followed consistently and the controlled drugs procedures include the disposal process.

Outstanding practice

- The practice had an effective and efficient leadership structure which included future practice planning. All staff shared the practice objectives to deliver high quality person centred care. There was a very strong quality and educational ethos in the practice through reporting and analysis of significant events and its audit programme.
- The patient participation group, known as the Wallingford patients in partnership (PIP) worked closely with the practice through monthly meetings. The PIP had organised a well-advertised and attended practice open day in 2014. This was now scheduled as an annual event. A representative of the PIP was recently involved in the interviews for a new GP partner.
- The practice had installed floor level wash basins to facilitate dressings changes for patients with leg and foot ulcers.

Dr A R Vernon and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP**.** The team included a CQC pharmacy inspector, a specialist in practice management and a specialist in practice nursing.

Background to Dr A R Vernon and Partners

Dr AR Vernon and Partners, also known as Wallingford Medical Centre, Medical Practice is located in purpose built premises in a semi-rural area in the grounds of Wallingford Community Hospital. It holds personal medical services (PMS) contract to provide primary medical services to approximately 16,300 registered patients. The practice dispenses prescriptions to approximately 3300 patients.

Care and treatment is led by six GP partners and four associate GPs. There are equal numbers of male and female GPs. The practice has three GP trainees, six practice nurses, administration, reception staff, dispensary staff and one practice manager; a total of 50 staff. The practice has been accredited to provide training to GP trainees.

The practice has a higher proportion of patients over the age of 40 years compared to the local Oxfordshire Clinical Commissioning Group (CCG) and national average and a lower proportion in the 15-34 year age group. The practice serves a population which is significantly more affluent than the national average.

The practice takes an active role within the Oxfordshire Clinical Commissioning Group (CCG) to develop services in the area.

The practice has opted out of providing out-of-hours services to its own patients. There are arrangements in place for patients to access care from an out-of-hours provider, NHS 111.

We visited the practice location at Wallingford Medical Practice, Reading Road, Wallingford, Oxfordshire, OX10 9DU.

Why we carried out this inspection

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 was 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.

This provider was inspected in July 2014 and we identified improvements were needed in relation to recruitment. We inspected the practice on 28 January 2015 to check whether improvements had been made.

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

Prior to the inspection we contacted the Oxfordshire Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch to seek their feedback about

Detailed findings

the service provided by Dr AR Vernon and Partners. We also spent time reviewing information that we hold about this practice including the action plan they provided following their previous inspection.

The inspection team carried out an announced visit on 28 January 2015. We spoke with 12 patients and 13 staff. We also reviewed 28 comment cards from patients who had shared their views and experiences.

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and notes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. Significant event reports covered a range of issues including concerns about possible child abuse, medicine errors, diagnostic delays and problems with the telephone system.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these. A dedicated meeting was held monthly to review significant events including actions and learning. 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 incident forms on the practice intranet and sent completed forms to the practice manager. We saw the system in place to track incidents to ensure they were monitored and managed in a timely manner. We reviewed 32 reports of significant events that had been identified and recorded in the previous 12 months. The practice encouraged reporting of significant events and used learning to improved patient safety. There were no recurrent themes identified in the significant events. We found they had been completed by GPs, nursing staff and administration staff on a range of incidents including prescribing, clinical decision making and poor communication with other providers.

National patient safety alerts were disseminated by the practice manager to practice staff. Nursing staff we spoke with confirmed they received alerts and took the appropriate action.

Reliable safety systems and processes including safeguarding

Systems were in place to safeguard children and adults. A designated GP partner was the practice lead for safeguarding children. Safeguarding policies and procedures consistent with the local clinical commissioning group (CCG) and Local Authority guidelines were in place to protect children and vulnerable adults.

Safeguarding information, including local authority contacts, were accessible on the practice intranet. Staff demonstrated an understanding of safeguarding children and vulnerable adults and the potential signs to indicate a person may be at risk. All staff had received training in safeguarding children. All GPs had level three safeguarding children training. At the previous inspection we found there was a lack of staff training on safeguarding adults. The practice had taken action and provided staff with adult safeguarding training and a named GP lead for adult safeguarding was identified. Staff were able give examples of where they had raised concerns about patients' safety in and outside the practice. There was a system to highlight vulnerable patients on the practice's electronic record system.

There was a notice displayed behind the reception desk to remind and prompt patients to request a chaperone if desired. (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). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Staff who undertook chaperone duties had disclosure and barring service (DBS) checks in place.

Medicines management

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

in the event of a potential failure. However, we found staff did not consistently follow this policy. We found six occasions when the temperature was out of range and no explanation had been recorded or action taken.

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.

The practice prescribing lead reviewed monthly prescribing date provided by the CCG and performance was discussed at monthly meetings. This showed the practice prescribing in all areas compared favourably with the CCG average.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We saw the practice had carried out a number of audits to monitor checks were carried out when these medicines were prescribed. For example, regular blood tests were taken and issues communicated to the NHS Trust hospital if appropriate.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank computer forms were stored securely, however, the recording of these blank forms was not in accordance with national guidance as these were not tracked through the practice.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. However, these did not include the disposal process. Staff demonstrated they were aware of how to handle CDs. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If prescriptions were not signed before they were dispensed, staff were able to demonstrate that these were risk assessed and a process was followed to minimise risk. We saw that this process was working in practice.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. The GP lead for dispensing analysed the reported dispensing errors. They supported dispensary staff to review the dispensary procedures to improve safety and reduce risks.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

The practice had established a prescription home delivery service for elderly patients and those patients who could not attend the practice due to illness or mobility issues.

Cleanliness and infection control

We observed the premises were clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Daily cleaning schedules were followed and monitored. We saw evidence that when issues were identified they were raised with the contractor.

Systems were in place to reduce the risks of spread of infection. A designated member of staff was the practice infection control lead person. They demonstrated a good understanding of their role. All staff had received training in infection control and were aware of infection control practices. For example, we observed staff used personal protective equipment such as gloves and saw that they disposed of clinical waste safely.

The practice infection control lead carried out fortnightly infection control audits. Our review of the last audit

showed improvements had been carried out, for example, wall mounted couch rolls were installed and foot operated bins. There was also a plan to replace carpets and soft furnishings with hard floors and washable materials as needed.

Equipment

Staff we spoke with told us they had sufficient 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 planned maintenance and testing schedule was followed. Regular checks on the premises and equipment were in place to ensure they were fit to use. For example, service checks on gas, electricity and fire equipment were all up to date. We saw evidence of testing of relevant equipment; for example, ECG machine and premises alarm.

Staffing and recruitment

Records we reviewed 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). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system 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 majority of practice staff worked part time which allowed for some flexibility in the way the practice was managed. For example, staff were available to work overtime if needed and available for annual leave and sickness absence cover. A bank of regular GP locums was used to ensure familiarity with practice procedures and a degree of continuity of care for patients.

There were recruitment and selection processes in place. Staff described the recruitment process which followed best practice guidelines. We reviewed a sample of ten files which confirmed the required pre-employment information had been sought. These included all the required information including a curriculum vitae or application form, one or two references, occupational health check, photographic identity and professional registration check. The practice had made improvements with regards to obtaining Disclosure and Barring Service (DBS) checks for all staff working at the practice or they carried out a DBS risk assessment to record a DBS check was not needed. For example, in the case of reception staff who did not carry out chaperone duties.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We were told issues and risks were discussed at GP partners' meetings and within team meetings. For example, staff cover during busy times, issues with the phone system and patient appointments. Meeting notes showed discussions took place and actions were agreed to improve the situation.

The practice had considered the risks of delivering the service to patients and staff and had implemented systems to reduce risks. We observed the practice was organised and tidy. We saw the provider had carried out a range of risk assessments reviewing environmental and personal risks, to ensure the health and safety of patients, visitors and staff members. For example, in relation to staffing, premises, fire and environmental issues such as inclement weather.

Good

Are services safe?

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 secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw notes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes and dermatology. GPs we spoke with were very open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines as part of their daily meetings and in their weekly clinical meetings.

We reviewed prescribing data from the local clinical commissioning group (CCG). Wallingford Medical Practice fully participated in all the elements of the local prescribing incentive scheme 2013/

14. It achieved two out of three areas of the scheme including a reduction in antimicrobial prescribing.

The practice identified 269 patients with complex needs who were at greater risk of admission to hospital. This was more than 2% of the practice registered list size. The practice ensured all these patients had a care plan in place and priority access to a GP via a dedicated phone line.

CCG data showed the practice was in the lower one third of referrals for all major specialities except for ear nose and throat (ENT). Where referral rates were higher than expected the practice carried out an audit to identify if improvements were needed and we saw an example of this for ENT referrals.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits. Daily searches were carried out on the disease registers of patients with long term conditions. These identified patients who had not attended for regular reviews and they were followed up with recall appointments to encourage attendance.

One of the GP trainers led on clinical audit. Monthly clinical meetings were held to discuss audit findings. The practice showed us seven clinical audits that had been undertaken in the previous 12 months. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. A wide range of clinical audits in a rolling audit programme had been undertaken which showed practice was measured against current best evidence and demonstrated adherence to current guidelines to monitor changes in practice and outcomes for patients. For example, one audit looked at blood test results for patients with gout. Recommendations were made to review patients with gout in line with accepted guidelines and re-audit in 12 months. Another audit was an annual audit of dispensing errors to identify if there were common trends. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance. Clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example, we saw an audit regarding the prescribing of high risk drugs which required regular blood tests to monitor patient safety and effectiveness.

The practice had consistently achieved 100% in the clinical domain of the Quality and Outcomes Framework (QOF) since 2006 and 100% overall for the last two years. The

Good

Are services effective?

(for example, treatment is effective)

practice was on track to achieve the same this year (2014/15). The QOF is part of the General Medical Services (GMS) contract for general practices. It is a voluntary incentive scheme which rewards practices for how well they care for patients. The practice maintained and managed patients with a range of long term conditions in line with best evidence based practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice had identified 531 diabetic patients and provided six monthly reviews for all its diabetic patients as they considered annual reviews to be insufficient to adequately monitor their condition. The majority of patients with long term conditions had received annual reviews of their condition: 93% of patients with chronic obstructive pulmonary disease (lung disease), 72% of patients with asthma and 100% patients with heart failure. Eighty per cent of patients with dementia had an annual review in the previous year. GPs worked with the community mental health team to develop care plans for patients with severe mental health conditions. This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance and support their GPs and nursing staff. Daily clinical meetings were held where GP trainees and trainers discussed issues and agreed a course of action for individual patients. This was supplemented by weekly tutorials for GP trainees. 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; this was facilitated by daily 'coffee morning' meetings and formal weekly clinical meetings.

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. We saw an example of an audit carried out as a result of a new alert of a potential drug interaction to review all patients prescribed the drug and ensure safe and effective prescribing. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with two GPs with a special interest in diabetes and one with a diploma in dermatology. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example diploma in dermatology for one of the GPs. As the practice was a training practice, doctors who were training to be qualified as GPs were allocated extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and contraceptive implant devices. Those with extended roles, for example in diabetes and asthma were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, x-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service, both electronically and by

Good

Are services effective?

(for example, treatment is effective)

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.

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

The practice held monthly multidisciplinary team meetings 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, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Discussion of palliative care patients followed the Gold Standards Framework for end of life care. The Gold Standards Framework is a systematic evidence based approach. It is designed to assist healthcare professionals to optimise care for all patients approaching the end of life.

The practice operated a GP buddy system which ensured all correspondence and results were managed in a timely manner to optimise patient care. The GP buddy system ensured all essential duties, for example, checking test results and signing prescriptions were completed when a GP was on leave.

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, the practice used the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice registration information included a leaflet on electronic patient records. The practice used the electronic Summary Care Record and planned to offer patients access to their electronic GP record by 31 March 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

Consent to care and treatment

We found that GPs were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. GPs and nurses were aware of what action to take if they judged a patient lacked capacity to give their consent. They told us they recorded best interest decisions, consulted carers with legal authority to make healthcare decisions and sought specialist advice if needed. One of the GPs told us they involved patients and families in discussions before completion of the do not attempt cardiopulmonary resuscitation form.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. All those patients had a care plan in place. 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 help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in

Good

Are services effective?

(for example, treatment is effective)

the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown an audit that confirmed the consent process for minor surgery had been followed in 100% of cases.

Health promotion and prevention

The practice was aware of the local area health priorities and more specifically in relation to their practice population.

It was practice policy to offer a health check with the health care assistant or 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 chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 1720 patients had a health check since the initiative started in 2011. A GP told us how patients were followed up promptly if they had risk factors for disease identified at the health check and how they scheduled further investigations.

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 51 out of 84 patients had an annual review of their condition so far this year and 100% last year. The practice had also identified the smoking status of 90% of patients over the age of 16 and 99% had been offered smoking cessation advice.

The practice's performance for cervical smear uptake was 83%, which was above average for the CCG area. Patients who did not attend for screening were followed up by the practice.

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 child immunisations was comparable to the CCG average for all age groups. The practice had a clear policy for following up non-attenders by the GP. The practice achieved 74% flu vaccine uptake in over 65 year olds in the previous year.

A range of information was available on the TV screen in the reception area and on the practice website, aimed at patients for health promotion and self-care.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. The most recent national GP survey data (January 2015), based on a good response rate of 123 surveys (47%) indicated very good satisfaction. The practice achieved above the clinical commissioning group (CCG) average in a number of areas. For example, 91% of respondents rated their overall experience of the surgery as good and 86% would recommend the surgery. The proportion of patients who stated staff were good at treating them with care and concern was 91% for doctors and 86% for nurses. Patients were also satisfied with the good listening skills of both GPs and nurses.

We spoke with 12 patients during the inspection. They were a mix of patients, male and female, parents with young children and older patients. All but one of the patients we spoke with had been with the practice for over five years. We also spoke with two representatives of the Wallingford patients in partnership PIP) group. All the patients we spoke with were extremely positive about the care and treatment they received. They told us staff provided compassionate care.

We received 28 comments cards from patients. All the comments were positive and referred to the kindness and consideration of GPs, nurses and reception staff. No negative comments were recorded.

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 reception desk was directly in front of the waiting area; a small room was located adjacent to the reception desk to provide privacy if needed.

All staff had received training on information governance and signed a confidentiality agreement at the start of their employment. Staff had a good understanding of confidentiality and how it applied to their working practice. For example, during the inspection we witnessed numerous caring and compassionate interactions between staff and patients which demonstrated how staff treated patients with dignity and respect.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 82% of practice respondents said the GPs and nurses were good at involving them in decisions about their care and 86% said GPs were good at explaining tests and treatment, compared to 87% for nurses, respectively. Both these results were above average compared to the CCG area.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Staff told us that translation services were available for patients who did not have English as a first language. However, staff confirmed the facility was very rarely used as the majority of patients could speak English.

Patients preferred methods of communication was recorded and the practice sought the patients consent before messages were left on answerphones.

GPs and nurses were aware of what action to take if they judged a patient lacked capacity to give their consent. They told us they recorded best interest decisions, consulted carers with legal authority to make healthcare decisions and sought specialist advice if needed. One of the GPs told us they involved patients and families in discussions before completion of the do not attempt cardiopulmonary resuscitation form.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection indicated patients were very positive about the emotional support provided by the practice. Bereaved patients were contacted by their named GP to offer support.

A list of palliative and vulnerable patients was updated daily. Staff were aware of patients or recently bereaved families so they could manage calls sensitively and refer to the GP if needed. A counsellor was offered to bereaved families for support.

Notices in the patient waiting room and patient website also told people how to access a number of support groups and organisations. Information on the TV screen in the waiting area included support groups for depression and bereavement. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. We were told the practice purchased a car from its own funds to provide a prescription home delivery service for patients who were unable to attend the practice due to illness or mobility issues. We saw the practice had installed floor level wash basins in all the treatment rooms. Practice nurses told us this facilitated the care of patients who required leg and foot ulcer dressings.

A daily phlebotomy (the process of taking blood from patients) service was offered and this began at 8am three days a week for patients who required certain blood tests. The practice offered a dispensing service for patients who lived more than a mile from a pharmacy, for their convenience.

The practice offered a number of services including an ear suction service, a full travel clinic service and was also accredited as a yellow fever centre.

A small number of patients with a learning disability and diabetes had been supported to manage their conditions. The practice nurses taught the patients' carers to administer insulin to the patients. This contributed to maintaining the patients' independence and impacted on their quality of life.

The practice valued the role of their patient participation group (PPG) or as they preferred to call it patients in partnership (PIP). The PIP is a forum for patients of the practice to share their experience and engage in improving the service for all patients. We reviewed the feedback from the 2014 annual survey. The majority of feedback was positive and suggested improvements included changes to the appointment system and the car park facilities. Both of which were under review by the practice. For example, the practice was raising awareness of the appointment system and was also in discussions with the estate department regarding the car park. The IT manager had a role in supporting patients to use the on line appointment service, they did this by telephone or face to face meetings. Over 100 patients had been enabled to use the on line system through this support.

Tackling inequity and promoting equality

The practice has a higher proportion of patients over the age of 40 years compared to the local Oxfordshire Clinical Commissioning Group (CCG) and national average and a lower proportion in the 15-34 year age group. The practice serves a population which is significantly more affluent than the national average. Life expectancy for males and females is higher than the national average. The practice population of patients identified from non-white ethnic groups was 2.5%.

The practice had access to online and telephone translation services. However, staff confirmed the facility was very rarely used as the majority of patients could speak English.

The practice maintained a register of all patients with a learning disability. One hundred per cent of patients on the register had annual reviews of their condition in 2013/14 and 51 out of 84 patients had an annual review of their condition so far this year.

The patient areas of the practice were all located on the ground floor of the premises. The low reception desk had been designed to accommodate the needs of patients in wheelchairs. 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 from 8am to 6.30pm daily. Extended surgery hours were provided by a surgery on Saturdays 8am to 12.30pm. This access was particularly useful to patients with work commitments.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The practice operated a flexible appointment system which involved a duty GP, to ensure all patients who needed to be seen the same day were accommodated. Longer appointments were available for people who needed them and those with long-term conditions. Named GPs visited five nursing homes weekly. Patients on the 'unplanned admission' register had a dedicated priority line for appointments or to speak to a GP.

Patients were satisfied with the appointments system. Three patients commented they had noticed an improvement in obtaining appointments in recent months. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. On the day we visited, patients told us they were able to obtain urgent and routine appointments when needed and our review of the appointment system record confirmed this.

Data from the national patient survey showed the practice could improve on access to appointments: 50% of respondents said they found it easy to get through to this surgery by phone compared to the local average of 85%. 76% of respondents find the receptionists at this surgery helpful compared to 87% and 73% of respondents describe their experience of making an appointment as good compared to 80%.

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 practice leaflet and website. 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 complaints received since April 2014. We found they were appropriately handled and dealt with in a timely way. The practice showed openness and transparency in dealing with the compliant. Three complaints had been reviewed at the 'significant event meetings' and learning shared. No complaint had been escalated to the Ombudsman.

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

We spoke with 13 members of staff and they all expressed pride in working at the practice. They told us they aimed to provide high quality care and promote good outcomes for patients. All staff shared the practice objectives to deliver high quality person centred care. The practice website and new patient leaflet included the practice aim to 'Treat all our patients promptly, courteously and in complete confidence'. The practice engaged with the local community through a regular feature in the local Wallingford magazine which was delivered to all households in Wallingford. The senior partner was the chair of the local learning disability charity and this was a priority area for the practice.

GP trainees were very positive about the teaching and training ethos at the practice. A number of past GP trainees had often applied for partner and associate vacancy when they arose. The practice worked on succession planning with both GPs and the practice management team to maintain the smooth running of the practice and its future development. The practice was planning to extend its premises to include more consulting rooms to meet the increasing demand for its services.

The practice worked collaboratively with the local clinical commissioning group (CCG) to develop services and identify priority areas.

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 seven of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All seven policies and procedures we looked were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, the senior partner was the lead for safeguarding adults and there was a lead nurse for infection control. Other partners had lead roles in finance, training, child protection and prescribing. We spoke with 13 members of staff and they 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 consistently achieved 100% in the clinical domain and 100% in total for the previous two years. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, referral patterns where the practice or an individual GP was identified as an outlier.

The practice had carried out a range of risk assessments reviewing environmental and personal risks, to ensure the health and safety of patients, visitors and staff members. The practice had a service continuity plan in place in case of emergency. Relevant contact numbers for staff and resources were recorded in the plan. These were to be used in the event of an incident that effected the operation of the service to ensure, where possible, alternative provision could be made and patients were appropriately informed.

The practice had arrangements for identifying, recording and managing risks. We saw risks were regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

The practice had a monthly schedule of meetings. These included business/ partners meetings, nursing, dispensary meetings and administration meetings. We looked at notes from the last two meetings and found that performance, quality and risks had been discussed.

Arrangements were in place to ensure staff were clear about their responsibilities and were familiar with practice procedures. An annual practice meeting schedule was in place which covered administration meetings, clinical meetings and business meetings. The meetings supported staff and ensured they were kept up to date with changes to practice systems. Staff told us they were comfortable to raise issues and concerns when they arose and were confident they would be dealt with constructively.

Every morning an informal clinical meeting was held which GPs and nurses told us they found very valuable in discussing day to day clinical issues and obtaining support from colleagues.

Are services well-led?

Good

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

The practice regularly reviewed its policies and procedures and implemented changes as a result of learning from serious events.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least 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 management team were responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment, confidentiality and whistleblowing, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

All staff spoke about a desire to provide high quality, patient centred care. The practice benefited from dedicated long serving staff. Staff described a supportive and inclusive environment where individual roles were valued. The GPs in the practice emphasised a strong focus on education and learning for all staff.

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

The Wallingford Medical Practice PIP consisted of eight core members. We spoke with two representatives of the PIP. They were very enthusiastic about their roles and were committed to working with the practice to improve services. PIP representatives also participated in external events such as a carers conference and national association for patient participation. The PIP held email addresses of approximately half of all its registered patients and used this method of communication. It was also mindful of patients who did not have internet access and used the local monthly Wallingford magazine to communicate messages to patients and the public.

The practice and PIP were proud of the practice open day held in April 2014. This had been publicised in the local press and featured competitions, talks by practice staff and local voluntary groups. One hundred and twenty people attended the open day. Another open day was planned for Summer of 2015 and expected to be an annual event going forward The PIP report from 2014 indicated that the group mainly consisted of older patients. However, they had an extended virtual group of 180 patients whose views were also sought. We reviewed the 2014 annual report and reviewed the annual survey results. We were told the survey response was significantly higher than in previous years; 1099 responses. The majority of feedback was positive and suggested improvements included changes to the appointment system and the car park facilities. Both of which were under review by the practice. For example, the practice was raising awareness of the appointment system and in discussions with the estate department regarding the car park. The PIP regularly contributed to the local Wallingford magazine which was distributed to all households in Wallingford and included 'News from PIP'.

The practice engaged with staff informally and formally 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 gave examples of when they had raised concerns if they felt it necessary. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff we spoke with were aware of the policy.

Staff told us they felt valued as part of the practice team. There were opportunities for formal and informal communication for staff, to ensure issues were raised and managed appropriately. An annual meeting schedule was in place which included significant event meetings, clinical meetings and practice business meetings. The practice welcomed feedback from the public, via a suggestion box in the reception area and the NHS choices website. The practice had recently introduced the NHS Friends and Family test.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training.

The practice had made improvements in the opportunities for training and training record keeping for all staff. Staff

Are services well-led?

Good

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

said they had mandatory training updates. For example, in infection control, child safeguarding and basic life support. Nursing and dispensary staff reported they were supported and had received appropriate training.

All the GPs mentioned the practice's focus on education and all staff said they had opportunities for development. All staff had been appraised in the last year. Staff told us they felt the appraisal was a meaningful process and identified areas for future personal development.

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