St George's Medical Centre PMS Practice

Quality Report

Roundhouse Medical Centre
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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 inspection visit on 02 December 2014 and the overall rating for the practice was good. The inspection team found after analysing all of the evidence that the practice was safe, effective, caring, responsive and well led. It was also rated as good for providing services for all population groups.

Our key findings were as follows:

- Where incidents had been identified relating to safety, staff had been made aware of the outcome and action taken where appropriate, to keep people safe.
- Patients received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to ensure they were up to date with best practice.
- Patients said staff were caring and respectful; they were involved in their care and decisions about their treatment.
- The service was responsive and ensured patients received accessible, individual care, whilst respecting their needs and wishes.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice including:

- A dedicated surgery afternoon is held for patients with a learning disability. This helped to offer the patient a better overall experience in meeting their needs.
- An anticoagulant clinic which was nurse led is offered to patients on long term Warfarin therapy. This has the benefit of providing a local service which is monitored by the practice.
- Travellers visiting the practice were opportunistically offered vaccinations for their children. This included extended family members and all those visiting the practice at the time of appointment.

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. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Patients' received care and treatment in line with recognised best practice guidelines such as the National Institute for Health and Care Excellence. Their needs were consistently met and referrals to secondary care were made in a timely manner. The practice worked collaboratively with other agencies to improve the service for people.

Are services caring?

Good

The practice is rated as good for providing caring services. The patients who responded to CQC comment cards and those we spoke with during our inspection, gave positive feedback about the practice. Patients described to us how they were included in all care and treatment decisions; they were complimentary about the care and support they received.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was responsive when meeting patients' health needs. There were procedures in place which helped ensure staff respond to and learn lessons when things do not go as well as expected. There was a complaints policy available in the practice and staff knew the procedure to follow should someone want to complain.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular meetings. Patients and staff felt valued and supported.

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 made provision to help ensure care for older patients was safe, caring, responsive and effective. All patients over 75 years had a named GP. There were systems in place for older patients to receive regular health checks, and timely referrals were made to secondary (hospital) care. Good information was available to carers.

People with long term conditions

Good

There were systems in place to help ensure patients with multiple conditions received one annual recall appointment wherever possible. They had care plans in place, including those who were at risk of re-admission to hospital. These were shared with the patient and reviewed by telephone. This helped to offer the patient a better overall experience in meeting their needs. An anticoagulant clinic which was nurse led was offered to patients on long term Warfarin therapy. This has the benefit of providing a local service which was monitored by the practice. Healthcare professionals are skilled in specialist areas and their on-going education supports them to follow best practice guidelines.

Families, children and young people

Good

The practice provided care for mothers, babies and young patients which were safe, caring, responsive and effective. The practice held family planning clinics, childhood immunisations clinics and maternity services. There was health education information, relating to these areas in the practice to help keep people informed.

Working age people (including those recently retired and students)

Good

The practice ensured care for working age people and those recently retired was safe, caring, responsive and effective. The practice had extended hours to facilitate attendance for patients who could not attend appointments during normal surgery hours. There was also an online booking system for appointments.

People whose circumstances may make them vulnerable

Good

The practice provided care for vulnerable people, who may have poor access to primary care which was safe, caring, responsive and effective. Travellers visiting the practice were opportunistically offered vaccinations for their children. This included extended family members and all those visiting the practice at the time of appointment. The practice has arrangements in place for longer appointments to be made available where patients required this

Summary of findings

and access to translation services when needed. A dedicated surgery afternoon is held for patients with a learning disability. This helped to offer the patient a better overall experience in meeting their needs.	
People experiencing poor mental health (including people with dementia) The practice provided care for people experiencing a mental health problem, including those patients with dementia; which was safe, caring, responsive and effective. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.	Good 

Summary of findings

What people who use the service say

We received 29 patient CQC comment cards where patients shared their views and experiences of the service. We also spoke with a patient who was part of the virtual Patient Reference Group (PRG).

Patients and comments from the CQC comment cards told us, the reception staff were courteous, kind and treated them with dignity and respect. They felt involved and supported in decisions about their care and were given a caring service.

Outstanding practice

- A dedicated surgery afternoon is held for patients with a learning disability. This helped to offer the patient a better overall experience in meeting their needs.
- An anticoagulant clinic which was nurse led was offered to patients on long term Warfarin therapy. This has the benefit of providing a local service which is monitored by the practice.
- Travellers visiting the practice were opportunistically offered vaccinations for their children. This included extended family members and all those visiting the practice at the time of appointment.

St George's Medical Centre PMS Practice

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 a practice manager.

Background to St George's Medical Centre PMS Practice

St George's Medical Practice has a main surgery at Roundhouse Medical Centre and a branch surgery at

Mapplewell Health Centre, in Barnsley. The branch surgery was not visited on this occasion.

The practice has three general practitioner (GP) partners (two male and one female). It is also a training practice for medical students and junior doctors. Working alongside the GPs are three practice nurses and a phlebotomist. There is an experienced management team including, a practice manager and administration/reception staff; a total of 17 members of staff are employed by the practice. The practice has a Personal Medical Services (PMS) contract. PMS is a locally agreed alternative to General Medical Service (GMS) for providers of general practice. Their registered list of patients is 6,300.

The main practice opening times are Monday and Friday 8am to 6.30pm, and Tuesday to Thursday 7am to 6.30pm. The branch surgery has specific opening times to meet the local needs and these are Monday to Friday 8.30am to 12.30md.

When the practice is closed patients will automatically be transferred to the Out of Hours service, Care UK, for care and advice.

A range of services are available at the practice and these include: vaccinations and immunisations, cervical smears, and chronic disease management such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and heart disease.

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as NHS England local area team and Barnsley Clinical Commissioning Group (CCG), to share what they knew.

Detailed findings

We carried out an announced inspection visit on 2 December 2014. During our inspection we spoke with staff including a GP, the practice manager, an advanced nurse practitioner and two reception staff.

We spoke with one patient who used the service; observed how patients were being spoken with on the telephone and within the reception area. We also reviewed 29 CQC comment cards where patients had shared their views and experiences of the practice.

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

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, national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents:
The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There was a record of six significant events that had occurred during the last years and we were able to review these. We were told by the practice manager and noted a meeting was held following all incidents with a focus on openness, transparency and learning when things go wrong. Action plans were reviewed at clinical monthly meetings and then annually to ensure actions from past significant events and complaints had been carried out. There was evidence the practice had learned from these and the findings were shared with relevant staff. Staff, including receptionists, administrators, and clinical staff, knew how to raise any issues and they felt encouraged to do so.

Safety alerts were reviewed by the practice manager and relevant staff and then discussed at the clinical/ staff meeting, together with the action they had taken.

Reliable safety systems and processes including safeguarding:
There were policies and protocols for safeguarding vulnerable adults and children. Staff had received training relevant to their role and this included safeguarding vulnerable adults and children training. We asked members of medical, nursing and administrative staff about their most recent training. They knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. GPs were using the required codes on their electronic case management system. This was to ensure risks to children and young people, who were looked after or on child protection plans, were clearly flagged and reviewed. The safeguarding lead GP was aware of the vulnerable children and adults on the practice patient list and records demonstrated there was frequent liaison with partner agencies such as, health visitors and social services.

In the practice waiting room we saw information offering the use of a chaperone during consultations and examinations. (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.) Staff told us they asked if patients would like to have a chaperone during an examination. Staff also told us when chaperones were needed the role was carried out by staff who had received the training.

Medicines management:
A representative from the Barnsley CCG Medicines Team supported the practice and gave advice on safe, effective prescribing of medication. This included the checking and advising on medicines that needed regular monitoring and reviewing, such as Warfarin. They also monitored and audited medicines to ensure the practice followed good practice guidance, published by the Royal Pharmaceutical society.

The GPs also monitored patient's medicines and this included those patients who were discharged from hospital. Patients told us reviews of their medication had taken place six to 12 monthly or more often depending on their individual needs.

We saw emergency equipment was available in the surgery which included emergency medicines. The practice had arrangements for managing medicines to keep patients safe and correct procedures were followed for the prescribing, recording, dispensing and disposal of

medicines. However, we did find that a medicine cupboard containing hormone medicines and a vaccines refrigerator were left unlocked. This was brought to the attention of the practice manager and the cupboard and refrigerator were immediately locked. Following the inspection the practice manager wrote to the CQC confirming the steps they had taken to make sure these areas were kept locked. We also saw records showing the antibiotics stored in the doctors bags were checked for expiry dates. Although we saw antibiotics which were in date, one of the drugs had expired. The out of date antibiotic was disposed of at the time of the inspection.

There were standard operating procedures (SOP) in place for the use of certain medicines and equipment. A nurse confirmed they used patient group directives (PGD). PGDs are specific written instructions which allow some registered health professionals to supply and/or administer a specified medicine to a predefined group of patients, without them having to see a doctor for treatment. For example, flu vaccines and holiday immunisations. PGDs ensure all clinical staff follow the same procedures and do so safely.

Vaccines were stored in the medicines refrigerator. Staff told us the procedure was to check the refrigerator temperature every day and ensure the vaccines were in date and stored at the correct temperature. Records showed in February, March, July and August 2014, there were occasions when the refrigerator temperature was as above the required temperature of 8°C. We noted the entry on the record showed the refrigerator was reset and the next recording showed it had returned to the required temperature. Staff confirmed the increase in temperature occurred when they had received a new batch of vaccines and the refrigerator door on these occasions, were open longer than usual. Following the inspection the practice manager provided information that they had spoken with staff, and assured us they would in future record any reason why the temperatures was higher than required to safely store vaccines.

Cleanliness and infection control:

We observed the premises to be clean and tidy. A cleaning company was employed by the landlord for the building. We saw there were cleaning schedules and audits took place. Patients we spoke with told us they always found the practices clean and had no concerns about cleanliness or infection control.

The practice nurse was the lead for infection control. An infection control policy and supporting procedures were available for staff to refer to and were last updated July 2014. We saw evidence they carried out regular infection control audits and a schedule was seen. This included areas, such as hand washing and cleaning of equipment. Actions as a result of the audits were completed in a timely way.

Equipment:

We saw equipment was available to meet the needs of the practice and this included: a defibrillator and oxygen, which were readily available for use in a medical emergency. Routine checks had been carried out to ensure they were in working order.

We saw equipment had up to date annual, Portable Appliance Tests (PAT) completed and systems were in place for routine servicing and calibration of medical equipment where required. The sample of portable electrical equipment we inspected had been tested and was in date.

Staffing and recruitment:

Records we looked at contained evidence of appropriate recruitment checks, 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).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. 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.

Monitoring safety and responding to risk:

The practice had clear lines of accountability for patient care and treatment. Each patient with a long term condition and those over 75 years of age had a named GP. The GPs, nurses and practice manager also had lead roles such as safeguarding lead, medicine management lead and infection control lead. Each lead had systems for keeping staff informed and ensuring they were using the latest guidance. For example, safety alerts were circulated

via email to staff and relevant changes were made to protocols and procedures within the practice. The practice manager and staff also told us the alerts were discussed at relevant staff meetings where the information was reinforced.

Areas of individual risk were identified. Information relating to safeguarding was displayed and staff had received relevant training.

Arrangements to deal with emergencies and major incidents:

There was a business continuity and management plan in place to ensure the smooth running of the practice in the event of a major incident. These included the loss of electrical or telephone systems. Staff were aware of the protocols should an incident occur and this included emergency contact numbers. We were told by the reception/administration staff that each day they printed out the GP and nurse's patient lists for the following day. If the computer system was not available the following day, then the staff would have the information they needed to continue with the service.

We found staff received annual cardiopulmonary resuscitation (CPR) training and staff we spoke with told us they were up to date with their training. Emergency medicines and equipment were accessible to staff and systems were in place to alert GP's and nurses in the event of an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment:

We found care and treatment was delivered in line with CCG and recognised national guidance, standards and best practice. For example, the clinicians used National Institute for Health and Care Excellence (NICE) quality standards and best practice in the management of conditions such as diabetes. We were told any updates were circulated and reviewed by the clinicians, changes made as required and these were discussed at the team meetings as appropriate.

The practice held multiple clinic appointments where appropriate, such as for those patients who had more than one long term condition. Other clinics included: new patient assessment, childhood immunisation and monitoring, antenatal and post natal clinics, general health checks and minor surgery.

The practice had registers for patient needing palliative care, diabetes, asthma, and COPD. This helped to ensure each patient's condition was monitored and that their care was regularly reviewed. Additionally regular palliative care meetings were held and they included other professionals involved in the individual patient's care.

Protocols from the local NHS trust were available and used to assist staff in maintaining the treatment plans of their patients. The practice used standardised local/national best practice care templates as well as personalised self-management care plans for patients with long-term conditions.

The practice raised awareness of health promotion during consultations with GPs and nurses. They also had health promotional literature available in the treatment rooms, the practice waiting areas and were brought to patients' attention through the practice website.

Management, monitoring and improving outcomes for people:

We found there were mechanisms in place to monitor the performance of the practice and the clinician's adherence with best practice to improve outcomes for people.

We saw the practice had a system in place for monitoring patients with long term conditions (LTC) and this included asthma, hypertension, Chronic Obstructive Pulmonary Disease (COPD), diabetes and learning disabilities. Care plans had been developed and they had incorporated NICE and other expert guidance. Examples of conditions where templates were used included asthma.

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF). The QOF aimed to improve outcomes for a range of conditions such as diabetes. The practice used the information they collected to help monitor outcomes for patients and the quality of services they provided.

We found clinical staff had a good awareness of recognised national guidelines. For instance they used National Institute for Health and Care Excellence (NICE) quality standards and best practice in the management of conditions such as diabetes and asthma. The practice had a system in place for completing clinical audit cycles and examples seen included COPD. We also saw minor surgical procedures took place in the practice in line with the GPs registration. The practice had a contract with the CCG regarding vasectomies and had written a protocol, for the service, which had been used nationwide.

The practice completed full health checks on new patients and followed up any identified health needs.

A palliative care register was also held and Gold Standard Framework (GSF) for end of life care, multidisciplinary meetings held to help ensure these patients received the best care possible.

Effective staffing:

Staff employed to work within the practice were appropriately qualified and competent to carry out their roles safely and effectively. This included the clinical and non-clinical staff.

The practice was a training practice for doctors who were training to be qualified GPs and they were supported by the GP partners and practice manager. There was an up to date 'locum pack' containing local protocols, procedure and guidance for them to follow.

The practice had advertised for a salaried GP, and following a successful interview recruited a Practice Nurse.

Staff confirmed and records demonstrated that new staff were provided with induction training and were monitored during their first few weeks in post. They were able to access relevant up to date policy documents, procedures and guidance.

Good

Are services effective?

(for example, treatment is effective)

Staff had annual appraisals where they identified their learning needs. The practice ensured all staff kept up to date with both mandatory and non-mandatory training and included: fire awareness, safeguarding adults and children and basic life support. Staff also confirmed they received training specific to their roles, for example, vaccinations and immunisation training and this included update training.

Working with colleagues and other services:
We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. There were regular meetings with multi-disciplinary teams within the locality.

Multidisciplinary meetings were held to discuss patients on the palliative care register and support was available irrespective of age.

Staff we spoke with felt they were listened to and involved in the running of the practice. There were clear lines of accountability and staff understood their roles.

The practice used a computer system to store patient records. Blood test results were received electronically from the laboratory; these and hospital discharge letters were allocated to the GPs for review and actioned where appropriate.

Information sharing:
Staff had access to electronic systems relevant to their role and all staff had access to up to date practice policies and procedures. Staff told us they were kept informed by the practice manager if there had been any changes to policies and procedures.

We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. There were regular monthly meetings with the multi-disciplinary team within the locality. These included palliative care nurses, health visitors, community matron, and district nurses; although due to workloads district nurses often were too busy to attend. There were also regular informal discussions with these staff. This helped to share important information about patients including those who were most vulnerable and high risk. The electronic system enabled timely transfer of information with the out of hour's providers and this included the local hospitals.

Consent to care and treatment:
We found the healthcare professionals understood the purpose of the Mental Capacity Act (2005) and the Children Act (1989) and (2004). All staff we spoke with understood the principles of gaining consent including issues relating to capacity.

They also spoke with confidence about Gillick competency assessments of children and young people, which were used to check whether these patients had the maturity to make decisions about their treatment. All staff we spoke with understood the principles of gaining consent including issues relating to capacity.

Patients felt they could make an informed decision. They confirmed their consent was always sought and obtained before any examinations were conducted. They told us about the process for requesting and using a chaperone and felt confident that it was effective as it was available to them when needed.

Health promotion and prevention:
All new patients were requested to complete a medical questionnaire and were offered a health screen examination with a practice nurse or health care assistant.

All patients over 75 years had a named GP and received an annual health check. Patients with a long term condition or mental illness had an annual review of their treatment, or more often where appropriate.

Child health clinics were held for immunisations and development assessments, and a doctor, nurse and health visitor were in attendance at routine screening of infants and to give parents advice.

The practice leaflet informed people about 'Self-treatment of common illnesses and accidents;' their web site promoted information about how to become healthy and it provided links to other websites such as the NHS Patient Information websites. A range of health information leaflets were also displayed in the practice waiting area. Additional clinics and services were available for patients within the practice. These included an anticoagulation clinic, a smoking cessation counsellor and a health trainer who advised on health related issues and living with long term conditions. This had the benefit of providing local, accessible services for patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy:
We received 29 patient CQC comment cards where patients shared their views and experiences of the service. We also spoke with a patient who was part of the virtual Patient Reference Group (PRG).

Patients and comments from the CQC comment cards told us, the reception staff were courteous, kind and treated them with dignity and respect. They felt involved and supported in decisions about their care and were given a caring service.

Patients were observed using the electronic booking in system. This allowed patients to maintain their privacy as they did not have to announce to the reception staff their name, when attending the practice for a booked appointment.

Staff were familiar with the steps they needed to take to protect people's dignity. We observed that staff were careful when discussing patients' treatments so that confidential information was kept private.

Staff offered the use of a consulting room, when patients wished to speak in private with a member of staff. All consulting rooms were private and patients who completed the CQC comment cards told us their privacy and dignity was always respected.

Care planning and involvement in decisions about care and treatment:
The patients we spoke with said they had been involved in decisions about their care and treatment. They told us their treatment was fully explained to them and they understood the information. They also said the staff responded to their treatment needs, they felt listened to and supported by staff and they were given a caring service.

Staff recognised when patients who used the practice and those close to them needed additional support to help them understand, or be involved in their care and treatment. There was access to language interpreters such as 'Big Word' for patients when needed and whose first language was not English.

Patient/carer support to cope emotionally with care and treatment:
We saw information in the practice about advocacy, bereavement support and counselling services. Staff were also aware of contact details for these services when needed.

The patients we spoke with on the day of our inspection told us, staff were caring and understanding when they needed help and provided support when required. The CQC patient comments cards also confirmed that all of the practice staff were supportive of their needs.

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.

We were told one of the GP partners was the Barnsley Clinical Commissioning Group (CCG) lead. As such, they engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

We were told by one of the GP partners and staff that in responding to patient needs, increased accessibility to appointments had helped reduce hospital admissions; Saturday morning appointments had commenced in March 2014.

Tackling inequity and promoting equality:
To facilitate attendance for patients the main practice was open from 7am three days a week. The extended hours allowed for flexible access for working age people, including those in full time education.

The practice had recognised the needs of different groups in the planning of its services. For example, the practice had systems in place which alerted staff to patients with specific needs who may require a longer appointment. For example, one afternoon a week they had clinic appointments for patients with a learning disability.

Child health clinics were held for immunisations and development assessments. The doctor, nurse and health visitor were in attendance for routine screening and parental advice.

All patients over 75 years had a named GP. There were systems in place for older patients to receive regular health checks, and timely referrals were made to secondary (hospital) care. Good information was available to carers.

Patients with a long term condition such as asthma and diabetes, had care plans in place and this included those who were at risk of re-admission to hospital. These were shared with the patient and reviewed by telephone. This helped to offer the patient a better overall experience in meeting their needs. An anticoagulant clinic which was nurse led was offered to patients on long term Warfarin therapy. This had the benefit of providing a local service which was monitored by the practice. Healthcare professionals were skilled in specialist areas and their on-going education supported them to follow best practice guidelines.

Travellers visiting the practice were opportunistically offered vaccinations for their children. This included extended family members and all those visiting the practice at the time of appointment.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

Access to the service:
Information was available to patients about appointments in their leaflet which was available in the patient waiting room and on their website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. If patients called the practice when it was closed, they were automatically transferred to Care UK, for the out-of-hours service.

Nurse appointment could be booked routinely for a variety of conditions and health promotion, including: asthma, COPD, diabetes, travel and childhood vaccines, and health checks.

Repeat prescriptions could be ordered on line, in person, by post, or by telephone using the practice dedicated telephone number. The surgery asked patients to state the practice they would like to collect there prescription from (the Roundhouse, main practice or Mapplewell, the satellite practice). Prescriptions were ready to collect within 48 hours, between 8am and 6.30pm.

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. 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 and this was located in the practice leaflet, in the waiting room and on their web

Good

Are services responsive to people's needs?

(for example, to feedback?)

site. Patients we spoke with were aware of the process to follow if they wished to make a complaint. Patients we spoke with had never needed to make a complaint about the practice.

We reviewed a record of complaints for the practice and saw that there were systems in place for reporting and receiving complaints. They had received one complaint in the year; we were told the outcome of complaints, actions required and lessons learned were shared with staff, during their meetings and staff confirmed this.

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:
There was an established management structure within the practice. The practice manager, GPs and staff were clear about their roles and responsibilities and the vision of the practice. They worked closely with the local CCG and were committed to the delivery of a high standard of service and patient care. They wanted to continue to deliver personal services to their patients, which met their needs. This included providing more appointments and therefore improved access to the service.

Monitoring took place, and this included audits to ensure the practice was delivering safe, effective, caring, responsive, and well led care.

Governance arrangements:
The practice had effective management systems in place. The practice had policies and procedures to govern activity and these were accessible to staff. We saw the policies incorporated national guidance and legislation, were in date; reviewed and updated. We found clinical staff had defined lead roles within the practice. For example, the management of long term conditions, safeguarding children and adults, and medication prescribing. Records showed and staff confirmed that they had up to date training in their defined lead role.

One of the GP partners was the Chair of the local CCG. The practice held meetings where governance, quality and risk were discussed and monitored. They used the Quality and Outcomes Framework (QOF) to measure their performance.

Leadership, openness and transparency:
The practice was committed to on-going education, learning and individual and team development of staff. The performance of staff was the subject of monitoring and appraisal at all levels; which reflected the organisational objectives. There were leading roles within the team for different aspects of the service. For example, vaccinations/ immunisation programme.

Staff we spoke with told us that all members of the management team were approachable, supportive and appreciative of their work. They had a proactive approach to incident reporting, team meetings between clinicians took place four to six weekly and information shared with the non clinical staff where appropriate, by the practice manager at their meetings; quarterly or more often when needed. Staff told us that in addition informal meeting also took place.

Staff also spoke positively about the practice and how they worked collaboratively with colleagues and health care professionals; for example, health visitors.

Practice seeks and acts on feedback from its patients, the public and staff:
We were told by the practice manager and staff, that correspondence with the Patient Representative Group (PRG) was by email. The practice manager emailed the PPG their last practice survey and with their help and suggestions in deciding the common themes patients were concerned about, the practice carried out surveys in November/ December each year.

The PRG survey report for 2014, identified one of the main themes was patients would like more available appointments. One response to this was the education of patients on the impact of them not cancelling appointment they were not able to keep. By patients cancelling these appointments, information collated over a three monthly period in March, April and May 2014, showed an extra four doctor and three nurse appointments could have been offered each day. These figures were displayed on a monthly basis on the practice electronic information board and in their practice newsletter. We were informed this had a huge impact on the availability of appointment each day.

The practice had gathered feedback from patients through patient surveys, and complaints received. We looked at the results of the annual patient survey and the main issue was access to appointments. We saw action had been taken such as reviewing the appointment system to ensure appointment availability and waiting times are appropriate. The practice newsletter, leaflet and website, reminded patients to cancel their appointment if not needed. These measures had been taken in working towards patients who needed to be seen had the opportunity.

Staff felt they could raise concerns at any time with the GPs, practice manager, or senior administrator. They were considered to be approachable and responsive. The

Are services well-led?

Good

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

practice had gathered feedback from staff through staff meetings and discussions. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement:

We saw there was a robust system in place for staff appraisals and staff had mandatory training and additional training to meet their role, specific needs. Mandatory training included: fire safety awareness, safeguarding vulnerable adults and children. The practice had clear expectations of staff attending refresher training and this was completed in line with national expectations. Staff we spoke with told us they felt supported to complete training and could request additional training which would benefit their role.

Staff were able to take time out to work together to resolve problems and share information which was used proactively to improve the quality of services. We saw minutes of meetings where issues had been discussed and proposed action as a result.