Manor Health Centre - SPM Magennis

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report from our inspection of Manor Health Centre. Manor Health Centre is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection on the 21 January 2015 at Manor Health Centre. We reviewed information we held about the services and spoke with patients, GPs, and staff.

The practice was rated as Good overall.

Our key findings were as follows:

- There were systems in place to mitigate safety risks. The premises were clean and tidy. Systems were in place to ensure medication including vaccines were appropriately stored and in date.
- Patients had their needs assessed in line with current guidance and the practice promoted health education to empower patients to live healthier lives.
- Feedback from patients and observations throughout our inspection highlighted the staff were kind, caring and helpful.
- The practice was responsive and acted on patient complaints and feedback.
- The practice was well led. The staff worked well together as a team and had regular staff meetings and training.

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 people safe. The practice was clean and tidy and there were effective medication management systems in place.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles. The practice carried out appraisals for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. The practice supplied information to help patients understand their treatment. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. 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, the Unplanned Admissions scheme. The practice had a designated named GP for patients who are 75 and over. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. GPs also visited local nursing and residential homes.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. All of the practice nurses were trained in chronic disease management and clinics were held on a weekly basis. All these patients had a structured annual review to check that their health and medication needs were being met. For those people with more complex needs, the practice referred patients to specialist nurses such as the Diabetic Liaison Nurse to visit them at home if required.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Appointments were available outside of school hours and the premises were suitable for children and babies with a toy area in the waiting room. The practice worked with midwives and health visitors.

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 practice opened two nights a week until 8.30pm for pre booked appointments with GPs and nurses. The practice's web site offered online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

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. It had carried out annual health checks for people with a learning disability. 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. For example a support group attended the flu clinics to give out advice about help available locally for carers.

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). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health. For example, the practice had quarterly meetings with the Psychiatry team from the local hospital to discuss the on-going care of patients. The practice also took part in the shared care scheme for dementia patients and these patients received six monthly review appointments.

The practice gave patients experiencing poor mental health access various support groups and voluntary organisations. However the practice had noted that waiting times for referrals for patients to access further mental health services in the area had increased and this was something they had highlighted to the local clinical commissioning group.

Summary of findings

What people who use the service say

As part of our inspection process, we asked for CQC comment cards for patients to be completed prior to our inspection.

We received 17 comment cards and spoke with four patients including representatives of the Patient Participation Group. The majority of comments received indicated that patients found the reception staff helpful, caring and polite and some described their care as excellent.

For the surgery, our findings were in line with results received from the national GP patient survey. For example, the latest national GP patient survey results showed that in January 2015, 96% of patients described their overall experience of this surgery as good (from 89 responses) and 97% found the receptionists helpful which is higher than the national average.

Results from the national GP patient survey also showed that 87% of patients said the last GP they saw or spoke to was good at treating them with care and concern which is higher than the national average.

Manor Health Centre - SPM Magennis

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) inspector and the team included a GP specialist advisor and practice manager specialist advisor.

Background to Manor Health Centre - SPM Magennis

Manor Health Centre is located in Liscard Village on the Wirral, which is in quite a deprived area of the country. There were approximately 5800 patients registered at the practice at the time of our inspection. The practice treated all age groups. The Health Centre was purpose built and a pharmacy is attached to the building.

The practice has three GP partners (one male and two female), a GP Registrar, a GP retainer and two other salaried GPs, four practice nurses, and a Health Care Assistant, reception and administration staff. The practice is normally open 8.00am to 6.00pm Monday to Friday and offers extended opening hours for early evening appointments two nights a week up to 8.30pm. The practice is a training practice and in addition to the GP Registrars taught medical students.

Patients requiring a GP outside of normal working hours are advised to contact an external out of hours service provider (Wirral Community NHS Trust out of hours services). The practice has a PMS contract and also offers enhanced services for example; various immunisation and learning disabilities health check schemes.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

How we carried out this inspection

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

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

Detailed findings

- Is it well-led?

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

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

Before visiting the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the Practice Manager provided before the inspection day. There were no areas of risk identified across the five key question areas. We carried out an announced visit on 21 January 2015.

We spoke with a range of staff including four of the GPs, two of the practice nurses, the Health Care Assistant, reception staff, administration staff and the Practice Manager on the day. We sought views from patients and representatives of the patient participation group and looked at comment cards and reviewed survey information.

Good

Are services safe?

Our findings

Safe track record

The Practice had a system in place for reporting and recording significant events. The practice had a significant event monitoring policy and a significant event recording form which was accessible to all staff via the practice's computers. Complaints verbal and written were also reviewed to ensure any information which may pertain to an incident was not missed. The practice carried out an analysis of these significant events and this also formed part of GPs' individual revalidation process.

Learning and improvement from safety incidents

We viewed written reports of the events, details of the investigations (root cause analysis) and learning outcomes. Minutes from weekly clinical staff meetings clearly demonstrated that discussions about any incidents took place. We looked at incidents that had occurred and found appropriate actions had been taken and new procedures had been implemented to reduce the risk of incidents happening again. The practice reviewed all incidents to identify any trends to see if any changes in practice protocols were necessary. For example there had been a number of significant events around patients receiving blood thinning medication and the practice had installed a service whereby these patients could have their blood tested at the practice to ensure the correct dosages of medication were given.

Any information with regards to national patient safety alerts or from the Medicines and Healthcare products Regulatory Agency (MHRA) was collected. Information was then cascaded to the appropriate staff members to ensure any action could be taken if necessary.

Reliable safety systems and processes including safeguarding

The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. In addition there were contact numbers displayed in the reception and treatment areas. There was a GP lead for safeguarding. All staff had received training at a level suitable to their role, for example all the GPs and lead had level three training. GPs attended safeguarding meetings when possible and provided reports where necessary for other agencies.

The practice had a computer system for patients' notes and there were alerts on a patient's record if they were at risk or subject to protection. The practice held internal safeguarding meetings to ensure patients were being appropriately monitored. For example, the practice held monthly meetings with Health Visitors to discuss children who may be at risk.

Practice nurses normally acted as chaperones if required and a notice was in the waiting room to advise patients the service was available should they need it. Staff involved in chaperoning had received training.

Medicines management

The practice had two fridges for the storage of vaccines. The practice nurses took responsibility for the stock controls and fridge temperatures. We looked at a sample of vaccinations and found them to be in date. There was a cold chain policy in place and fridge temperatures were checked daily. Regular stock checks were carried out to ensure that medications were in date and there were enough available for use.

Emergency medicines such as adrenalin for anaphylaxis were available. These were stored securely. One of the practice nurses had overall responsibility for ensuring emergency medication was in date and carried out monthly checks. Emergency drugs were also available in GP bags for home visits. All the emergency medication was in date.

The practice had an electronic prescribing system but occasionally also used paper prescriptions; these were securely stored and managed.

The practice had a repeat prescribing policy in place and there were clear guidelines available to patients both in the practice information leaflets and the practice web site on how to order and collect prescriptions.

The practice had a Medicines Manager and also worked with pharmacy support from the local Clinical Commissioning Group (CCG) and carried out medication audits and medication reviews to ensure patients were receiving optimal care in line with best practice guidelines. For example, audits had been carried out for prescribing

following discharge from other health care settings, for example from hospital. We saw annual reviews from the local CCG medicines management team that demonstrated the practice was prescribing in line with best practice for certain medications such as anti- depressants.

Cleanliness and infection control

All areas within the practice were found to be clean and tidy. The practice was cleaned every day by an external company. We saw audits to confirm that there were monthly monitoring checks to ensure the practice cleanliness was acceptable. Comments we received from patients indicated that they found the practice to be clean.

Treatment rooms had the necessary hand washing facilities and personal protective equipment (such as gloves) was available. Hand gels for patients were available throughout the building. Appropriate clinical waste disposal facilities and contracts were in place and spillage kits were available. There was appropriate guidance and facilities in place for the disposal of sharp instruments and staff we spoke with were aware of what to do should they injure themselves with for example, a needle.

One of the practice nurses was the designated lead for infection control. The practice nurse had undergone training suitable for this role and told us they would receive e-mail alerts for infection control updates from the local infection prevention and control team. All staff received annual infection control training and there were policies and procedures in place which were easily accessible for all staff on the practice's computer system.

The local infection prevention and control team had carried out an audit at the practice in July 2014. Where there had been areas identified for improvement, we saw that these had been addressed. For example, disposable curtains had been introduced in treatment rooms. We saw a Legionella risk assessment for the practice and regular monitoring took place.

Equipment

The Practice Manager ensured all electrical equipment had received a portable appliance check to ensure the equipment was safe to use. All faults with main equipment for the building were reported to the Practice Manager.

Clinical equipment in use was checked to ensure it was working properly. For example blood pressure monitoring equipment was annually calibrated.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However this did not include information about Disclosure and Barring Scheme (DBS). However all staff had received DBS checks and the Practice Manager told us they would update the policy to reflect the actual actions the practice took when recruiting staff. We looked at three staff files and recruitment documentation and found all necessary checks had been carried out including checking annually professional registration status for nurses.

The practice had a low turnover of staff and the majority had been with the practice for many years. Staff we spoke with felt there were enough staff and in the event of unexpected absences the team covered each other's leave.

Monitoring safety and responding to risk

There were procedures in place for monitoring and managing risks to patient safety. All new employees working in the building were given induction information for the building which covered health and safety and fire safety.

There was a health and safety policy available for all staff and the Practice Manager carried out routine maintenance checks for the building.

There was a fire risk assessment in place and the practice regularly had fire equipment tested. The practice also carried out regular fire drills.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. The practice premises also had panic buttons installed.

All staff received annual basic life support training and there were emergency drugs available in the treatment room on the ground floor. The practice had oxygen and a defibrillator available on the premises.

Staff we spoke with knew what to do in the event of a medical emergency and how to also reassure other patients or relatives present. They told us that any emergency was discussed as an incident so that any learning points could be shared. Staff knew where to record

Good

Are services safe?

any accidents or incidents and there was a first aid box available. Staff noticeboards in the reception area displayed how to deal with patients calling in the event of emergencies and basic life support guides for easy access.

The practice had a comprehensive business contingency plan in place for major incidents such as power failure or building damage. The Practice Manager had the foresight to recognise people can easily panic when faced with emergency situations and had implemented a 'grab' file containing easy read plans for different types of eventualities and also had these plans stored off site.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Once patients were registered with the practice, one of the practice nurses carried out a full health check which included information about the patient's individual lifestyle as well as their medical conditions. The practice nurse referred the patient to the GP or other clinic within the practice when necessary.

The practice carried out assessments and treatment in line with best practice guidelines and had systems in place to ensure all clinical staff were kept up to date. We spoke with the Nurse Manager who would cascade any information to other practice nurses and had information available for staff such as updates on National Institute for Health and Clinical Excellence (NICE) guidance.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register, learning disabilities and palliative care register.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice. The practice held meetings to regularly discuss practice performance and improvements in QOF and to ensure targets were met. The practice results for QOF totals (2013-2014) were higher than the local average and national average.

The practice had looked at their Inspection Monitoring outcomes and where there had been an area of concern they had taken action to address. For example they had looked at how they treat patients with dementia and had staff trained in dementia awareness.

Clinical staff met weekly to discuss the management of individual cases. The practice also met with the local Clinical Commissioning Group (CCG) to discuss performance. GPs carried out clinical audits and re-auditing took place. Examples of audits included looking at antibiotic prescribing in respiratory infections and the practice was also involved in a local audit looking at cancer referral rates. Learning points from clinical audits were routinely discussed at staff meetings.

Effective staffing

The practice had a comprehensive induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality. There was a staff handbook and a training policy in place. All staff received training that included: - safeguarding vulnerable adults and children, equality and diversity, fire awareness and basic life support on a regular basis to ensure they were up to date with the latest guidance. The practice nurses also attended local meetings and training events organised outside of the practice.

There were embedded appraisal systems in place. The Practice Manager oversaw the appraisals of all non- clinical staff. Staff we spoke with felt well supported and told us they were encouraged to attend training courses if they so wished. The practice was a training practice with a GP registrar and GP retainer. They told us the practice provided excellent training and that they felt well supported and received specific tutorials.

All GPs were up to date with their yearly continuing professional development requirements and they had been revalidated. (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).

The practice had lead GPs for various clinical and medical roles and the practice nurses supported the GPs. For example, there was a GP who was lead for diabetes who was supported by one of the nurses. The nursing staff all had specialist interests and there was a good skill mix to cover patients medical needs. Staff had undergone additional training for their roles.

Working with colleagues and other services

The practice had access to patients' blood tests and X-ray results from local hospitals and had a system in place for recording information on to patients' medical records. Cases which required immediate follow up were flagged up

Good

Are services effective?

(for example, treatment is effective)

on the practice's computer task system for the GP to action. Each GP could access their patients' follow up requirements. Urgent information was given directly to the GP. Patients were contacted as soon as possible if they required further treatment or tests.

Patients were referred to hospital using the 'Patient Choose and Book' system. Patients who had been referred under the two week rule (i.e. urgent referrals such as cancer) and who failed their hospital appointment were followed up by GPs to ensure they received timely tests.

We saw evidence to show that the practice was in the process of auditing how the practice dealt with letters received from other healthcare professionals. A sample of letters received after patients were discharged from hospital were being reviewed to ensure that all information pertaining to the patient's healthcare needs including medication were being met and whether any improvements to the practice's systems were required.

Information sharing

Systems were in place to ensure information regarding patients was shared with the appropriate members of staff. There was a staff noticeboard in the reception area which had flow charts to guide staff as to how they should deal with patient information from and to other healthcare professionals to ensure patient data was kept confidential. Information about individual clinical cases was shared at staff meetings. For example, the practice in conjunction with community nurses and matrons held monthly multidisciplinary Gold Standard Framework meetings for patients who were receiving palliative care and minutes of these meetings were available to all staff involved.

The practice used summary care records to ensure that important information about patients could be shared between healthcare settings. The practice liaised with the out of hours provider regarding any special needs for patients. The practice had formulated a report template to ensure appropriate information about a patient was sent to the out of hours service.

The practice operated a system of alerts on patients' records to ensure staff were aware of any issues for example alerts were in place if a patient was a carer or lived alone.

Consent to care and treatment

We spoke with four of the GPs about their understanding of the Mental Capacity Act 2005. They provided us with examples of their understanding around consent and mental capacity issues and how best interest meetings had been arranged when necessary. GPs had recently received Mental Capacity Act 2005 refresher training and one of the GPs was a designated mental health lead.

The GPs were aware of Gillick guidelines for children. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

The practice carried out minor surgery and we found appropriate consent forms for patients were in place.

Health promotion and prevention

The practice placed a strong emphasis on health promotion by having a variety of patient information available to help patients manage and improve their health. There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including information on strokes, meningitis, cancer and immunisations. The practice web site had a range of information and useful links for further supporting information for a variety of long term conditions such as diabetes and asthma. There was also information available about family health including about vaccination schedules for infants and how to deal with more common minor illnesses.

The practice nurses held a variety of clinics for specific problems and general health checks. There was a diabetic clinic, respiratory clinic for patients with asthma for example and cardiovascular clinic for patients with problems with heart or vascular diseases or stroke. There was a lifestyle management clinic that had recently been introduced to give patients advice on such matters as losing weight and smoking cessation. The practice also operated NHS health checks for patients between 40-74 years of age.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone.

CQC comment cards we received and patients we spoke with all indicated that they found staff to be helpful, caring, and polite and that they were treated with dignity. Results from the national GP patient survey also showed that 87% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 90% said the last GP they saw or spoke to was good at listening to them which is higher than the national averages.

Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We saw that patients were asked to stand away from the reception area if waiting to be seen to avoid private discussions being overheard. The practice had a confidentiality policy in place.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey also showed that 88% said the last GP they saw or spoke to was good at explaining tests and treatments and 83% said the last GP they saw or spoke to was good at involving them in decisions about their care which was slightly lower than the local average of 86%. Ninety five percent of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care which was higher than the local average.

Comments received from patients highlighted that they felt listened to by GPs, were referred appropriately and were supported in terms of managing either long term or acute illnesses.

Patient/carer support to cope emotionally with care and treatment

Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed that they would offer them a private room to discuss their needs. The Practice Manager told us that patients with emotional issues were contacted and could be signposted to various bereavement counsellors and support organisations to ensure their needs were being met. The practice web site contained a specific section for patients who required support in times of bereavement.

There was supporting information to help patients who were carers which was available on a dedicated page on the practice's website. The practice also kept a list of patients who were carers and alerts were on these patients' records to help identify patients who may require extra support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Manor Health Centre had an established patient participation group (PPG). Adverts encouraging patients to join the PPG were available in the waiting room and on the practice's website. The PPG met once a month and agreed formats for patient surveys which were sent out annually.

We spoke with the Chairperson for the PPG and two other representatives who told us the practice management had been responsive to any of their concerns. For example the practice had set up a blog on the internet to try to encourage younger patients to feedback their views on the service. The practice had also increased the amount of health information available to patients in response to the last survey in 2014 by installing an additional television display and further information leaflets in the waiting room.

Some patients in the survey had requested having meetings about carers. The practice in response had arranged for a local support group to attend the practice to sign post patients to the relevant services which were available locally.

Tackling inequity and promoting equality

The surgery had access to interpreter services (language line) but staff told us they had rarely had to use this facility. The practice web site also had a translation facility and could be accessed in any language format. The reception desk was fitted with a hearing loop. All staff received training about Equality and Diversity.

The building had disabled facilities including access and a lift.

Access to the service

The practice is normally open 8.00am to 6.00pm Monday to Friday and offered extended opening hours for early evening GP and nurse appointments two evenings per week. Patients could make appointments either by telephone, on line or by visiting the practice. The practice had set up a system whereby patients were reminded of their appointments by text messaging.

There were notices in the waiting room to advise patients that if they had more than one medical problem that needed attention, they should book a double appointment. The practice carried out telephone consultations and home visits when necessary.

Fifty percent of appointment slots were for urgent appointments on the day. There was a safety system in place so that patients who could not be given a time to be seen were called back by the GP at the end of the surgery session and asked to come to the surgery if necessary.

Listening and learning from concerns and complaints

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

Information about how to make a complaint was available on the practice's website and in the waiting room. The complaints policy clearly outlined a time framework for when the complaint would be acknowledged and responded to. In addition, the complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint.

The practice not only recorded written complaints but also logged all verbal complaints in order to identify any trends. Learning points from complaints were discussed at staff meetings and all patients were written to with an explanation and apology when things had gone wrong.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice's mission statement was 'to provide a comprehensive, progressive high quality service, caring for the needs of patients and the practice team in a manner which makes the best use of resources'.

Comments we received were very complimentary of the standard of care received at the practice.

One of the practice's aims was to 'produce a culture of appropriate and high quality learning for all staff'.

All staff were engaged in producing a high quality service and each member of staff had a clear role within the structure of the practice. For example, there were leads for safeguarding and infection control and a Medicines Manager and a Nurse Manager.

The practice was engaged with the local Clinical Commissioning Group (CCG) to ensure services met the local population needs. The practice had business plans in place to develop and maintain future services.

Governance arrangements

The practice had a GP lead for clinical governance and a policy outlining the arrangements for the practice. The policy outlined key areas of management of the practice such as patient involvement and reviewing feedback, using clinical audit and evidence based medical treatment, information governance, risk management and staff education.

The practice had policies and procedures to support governance arrangements which were available to all staff on the practice's computer system. The policies included a 'Health and Safety' policy and 'Infection Control' policy. All policies were in date and regularly reviewed.

Staff we spoke with were aware of how to access all policies and protocols and we saw that some protocol information was covered at induction. However some staff were not as certain as they could be about the existence of the whistleblowing policy. The Practice Manager told us they would check staff understood the protocols in place.

Personal development was encouraged and supported by appraisals for all staff. GPs carried out appraisals for the Nurse Manager and the Nurse Manager carried out appraisals for the other practice nurses and Health Care Assistant.

Leadership, openness and transparency

The practice had a clear leadership structure which had named members of staff in lead roles for oversight of the performance and monitoring of the practices. For example there was one lead GP who was responsible for information governance.

The practice had weekly staff meetings which were broken down into smaller meetings for clinical staff, nurses and reception/administration staff to ensure all staff had an opportunity to be involved in the running of the practice. Minutes for all GP meetings were recorded and kept on the practice's computer systems which all staff could access. However, minutes for other meetings such as for the nurses were not kept and the Practice Manager told us this would be addressed.

Members of staff were supported at the practice for example there was a 'zero tolerance policy' to prevent and cope with any untoward behaviour from patients against the practice staff.

The management team told us they operated a 'no blame' culture and adopted a non-judgemental attitude if mistakes were made. This was confirmed by members of staff we spoke with who thought they were well supported and the culture within the practice was very friendly open and honest. Many staff had worked at the practice for many years and clearly worked very well as a team and enjoyed their work.

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

Results of surveys and complaints were discussed at staff meetings. There was a patient participation group in place and minutes from meetings and results of surveys demonstrated actions were taken when necessary. We spoke with the chair of the PPG who told us there were no concerns at present and felt that the practice was responsive to any issues raised by the group.

The practice had the new Friends and Family Test as a method of gaining patients feedback since December 2014.

Are services well-led?

Good

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

Not all staff we spoke with were aware there was a whistleblowing policy in place but they knew what to do if they had to raise any concerns.

Management lead through learning and improvement

GPs were all involved in revalidation, appraisal schemes and continuing professional development.

The practice held weekly GP partner meetings every Monday where any issues from the past week were discussed and any forward plans. After this meeting there was a clinical meeting involving the GPs and the Nurse Manager. The meetings had fixed agendas which included discussing any complaints or incidents. District Nurses attended these meetings on a monthly basis to discuss patients on Gold Standard Framework. Any relevant information from these meetings was cascaded by the Nurse Manager to a nurses meeting. Reception and administration staff also had separate weekly meetings.

The practice was also involved in meetings with the local CCG, multidisciplinary meetings for the Gold Standard Framework and Neighbourhood meetings.