Watling Medical Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced, comprehensive inspection at Watling Medical Practice on the 23 June 2015.

Overall the practice is rated as good.

Our key findings were as follows:

- The practice had recently appointed a new practice manager who had begun to introduce new methods of improving communications for the staff team and to engage patients to provide feedback about the practice to drive forward future improvements.
- There were systems in place to mitigate safety risks including analysing significant events and information from complaints. 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 placed a strong emphasis on the continuity of care with one GP being responsible where possible for each episode of care. The practice had specific clinics for chronic disease management such as asthma and diabetes.
- The practice embraced medicines optimisation (a person centred approach to safe and effective use of medicines).The GPs ensured patients who had been advised to take new medications from other clinics were reviewed appropriately. They took time with patients to ensure that they understood how to take their medication and to ensure the medication was appropriate for them.
- The practice accommodate other visiting healthcare professionals and advisory groups so that patients did not have to be referred elsewhere.
- Feedback from patients and observations throughout our inspection highlighted the staff were respectful caring and helpful.

There were also areas of practice where the provider needs to make improvements.

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Summary of findings

The provider should:

- Ensure that there are two signatures from staff when accessing controlled drugs.
- Ensure information and key learning points from complaints and incidents are disseminated to the whole practice team.
- Consider expanding the range of audits to include any minor surgery treatment and dispensing practices.
- Ensure staff receive training about the Mental Capacity Act 2005.
- Ensure complete documentation of recruitment files.

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. However learning points were not communicated to the whole practice team to support improvement. There were safe processes in place to ensure the safeguarding of children and vulnerable adults and for dealing with medical emergencies.

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 the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff received appraisals. Staff worked with multidisciplinary teams and proactively managed patient's care.

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. Comment cards we received indicated patients were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. 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 local 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. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available.

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 the new practice

Summary of findings

manager. The practice had a number of policies and procedures to govern activity and there were weekly meetings with the GP partners and the practice manager. The practice manager was in the process of developing a new patient participation group.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs and longer appointments where necessary. The practice had invested in electronic couches in all their consultation rooms which were easier for older patients to use.

The practice had access to community intervention beds which were utilised by the practice for those patients requiring care and rehabilitation when hospital admission was not appropriate. GPs attended weekly meetings with other healthcare professionals to monitor patients' care.

People with long term conditions

Good

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

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. Immunisation rates were relatively high for all standard childhood immunisations and there were systems in place to follow up appointments for children who did not attend. There was a named lead GP to oversee child health safety.

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 had adjusted the services it offered to ensure these were accessible,

Summary of findings

flexible and offered patients the same GP for each episode of care to ensure continuity. The practice offered online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% 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. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The practice also provided services for a women's refuge centre.

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 four percent of people experiencing poor mental health had an agreed care plan in place. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations and there was an onsite counselling service available.

Summary of findings

What people who use the service say

As part of our inspection process, we asked for CQC comment cards to be completed by patients prior to our inspection. We received 11 comment cards. Reception staff, nurses and GPs all received praise for their professional care and patients said they felt listened to and involved in decisions about their treatment. Patients informed us that they were treated with compassion and that GPs went the extra mile to provide care when patients required extra support.

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, 86% of patients described their overall experience of this surgery as good (from 126 responses) and 89% found the receptionists helpful which is higher than the local clinical commissioning group (CCG) and national averages.

Results from the national GP patient survey also showed that 77% of patients said the last GP they saw or spoke to was good at treating them with care and concern which is slightly lower than the local CCG average of 82% but 98% had confidence and trust in the last GP they saw or spoke to.

Seventy two percent of patients found it easy to get through to the surgery by phone which is higher than the local CCG average of 53% but similar to the national average of 74%.

Eighty five percent of patients surveyed would recommend the practice to someone new to the area which is much higher than the local CCG average of 71% and the national average of 78%.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that there are two signatures from staff when accessing controlled drugs.
- Ensure information and key learning points from complaints and incidents are disseminated to the whole practice team.
- Consider expanding the range of audits to include any minor surgery treatment and dispensing practices.
- Ensure staff receive training about the Mental Capacity Act 2005.
- Ensure complete documentation of recruitment files.

Watling Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP specialist advisor and practice manager specialist advisor.

Background to Watling Medical Practice

Watling Medical Practice is located in a busy high street in Northwich town centre and is the result of a merger of two practices. At the time of the visit there were 7453 patients on the practice list and the majority of patients were of white British background.

The practice has five GP partners (three male and two female). There are three nurses and reception and administration staff including a practice manager. The practice is open 8.30am to 6.00pm Monday to Friday. The practice does not provide extended hours opening. Patients requiring a GP outside of normal working hours are advised to contact the surgery and they are then directed to contact the external out of hours service provided by Nights Evenings and Weekends (NEW), based at Leighton Hospital.

The practice has a General Medical Service (GMS) contract and also offers enhanced services for example; various children's immunisation and avoidance of unplanned hospital admissions schemes.

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?
- 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

Detailed findings

• 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 provided before the inspection day. We carried out an announced visit on 23 June 2015. We spoke with a range of staff including four GPs, two nurses, reception staff and administration staff and the practice manager, on the day. We looked at comment cards and reviewed survey information.

Good

Are services safe?

Our findings

Safe track record

There was a system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. All complaints received by the practice were fed into this system and automatically treated as a significant event. The practice carried out an analysis of the significant events and this also formed part of GPs' individual revalidation process.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. There was a log of safety incidents kept and there was a low threshold to reporting.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration and they felt encouraged to do so.

Clinical staff meetings were held weekly to discuss learning from complaints or incidents however there were no systems in place to cascade any learning points to the whole practice team. We viewed documentation for recent significant events which included details of the events and learning outcomes for what could be improved. One report of an incident demonstrated the lessons learnt had been shared with other practices in the area and another whereby the patient had been duly informed of what had happened and an apology made for any inconvenience caused.

The practice had a system in place to implement safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). For example, we could see information for patients about the Ebola outbreak in West Africa displayed in the waiting area.

Reliable safety systems and processes including safeguarding

The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff.

There were flowcharts on display in the reception manager's office outlining the safeguarding procedure and who to contact for further guidance if staff had concerns about a child's welfare.

There was a lead member of staff for safeguarding vulnerable adults and a separate lead for safeguarding children. All clinical staff told us they had received safeguarding children training at a level suitable to their role, for example the GPs had level three training. Staff had also received safeguarding vulnerable adults training and understood their role in reporting any safeguarding incidents.

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 identified as at risk. Children who failed to attend appointments were actively followed up by the practice and the clinicians gave us examples of how the practice team worked closely with the health visitor if any concerns were identified.

The nurses acted as chaperones if required and a notice was in the waiting room to advise patients the service was available should they need it. All staff who acted as chaperones had received a disclosure and barring check (these checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

The practice worked with pharmacy support from the local CCG. Regular medication audits were carried out to ensure the practice was prescribing in line with best practice guidelines.

The practice had two fridges for the storage of vaccines. One of the nurses took responsibility for the stock control 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 and available in

the dispensary area. In addition there was emergency adrenalin available in each consultation room. One of the nurses had overall responsibility for ensuring emergency medicines were in date and carried out monthly checks. All the emergency medicines were in date.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

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. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted. There was a controlled drugs log book available and we found that only one member of staff was signing for access to drugs as opposed to the two signatures required. We were told that another member of staff would witness the procedure.

The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines. We were told the practice had previously been signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained however there were limited audits available. Dispensing staff had all completed appropriate training and had their competency annually reviewed at their appraisal.

Cleanliness and infection control

Comments we received from patients indicated that they always found the practice to be clean. We found the practice appeared clean, however, on checking one of the treatment rooms and a consultation room, there was a thick layer of dust in some areas. We discussed this with the practice manager who was new in post, had had only recently put monitoring checks in place. We were assured that more robust monitoring systems would be implemented in the future.

Treatment rooms had the necessary hand washing facilities and personal protective equipment (such as gloves) was available. Hand washing gels were also available throughout the building.

Clinical waste disposal contracts and facilities were in place and spillage kits were available. Staff knew what to do in the event of a sharps injury and appropriate guidance was available. A separate room was available for those patients who may attend the practice with infectious diseases, such as measles for example, to reduce the risk of other patients acquiring the disease.

One of the nurses was the designated clinical leads for infection control. As part of their role, they attended external meetings to keep up to date with any latest guidance and cascaded the information back to the practice. There was an infection control policy in place and staff had received up to date training.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

The practice took part in annual external audits from the local community infection control team and acted on any issues where practical for example the practice had installed foot pedal operating bins in response to audit action points.

Equipment

All electrical equipment was checked to ensure the equipment was safe to use. Clinical equipment in use was checked to ensure it was working properly. For example blood pressure monitoring equipment was annually calibrated. Staff we spoke with told us there was enough equipment to help them carry out their role and that equipment was in good working order.

One of the nurses carried out regular checks on emergency equipment such as the defibrillator.

Staffing and recruitment

Staff covered for each other in the event of unplanned absences. Not all staff agreed there was enough staff and they felt stretched especially if someone was on leave. Two nurses were leaving the practice (one on maternity leave) and the practice was in the process of interviewing applicants. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. All staff working at the practice had received a disclosure and barring service check to ensure they were suitable to carry out their role or a risk assessment was in place to ascertain the need for a check.

Good

Are services safe?

We reviewed a sample of three files and certain documents that should be in place such as medical fitness checks were not available and one file did not contain any documented references.

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 a health and safety poster displayed in the reception area. There was a risk assessment in place for potentially hazardous materials on the premises (Control of Substances Hazardous to Health COSHH).

There was a fire risk assessment in place. Staff confirmed they carried out fire drills and were well versed in what to do in the event of fire. There was regular testing of smoke detectors and fire fighting equipment was checked annually.

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. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. However some staff we spoke with were not aware of the existence of the plan or said they would check the computer, but if the computer system was the problem, there was no hard copy of the plan for staff to easily access.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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. 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 and palliative care register.

In discussions with the GPs we were given several examples of how the practice acted proactively to manage patient care. The practice also took part in the avoiding unplanned admissions scheme. The clinicians discussed patient's needs at meetings to ensure appropriate care was delivered.

The practice embraced medicines optimisation (a person centred approach to safe and effective use of medicines).The GPs reviewed patients who had been prescribed new medications from other clinics. They took time with patients to ensure that they understood how to take their medication and also to ensure the medication was appropriate for them.

Interviews with GPs showed that the culture in the practice was that patients were cared for and treated solely based on need.

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 was not an outlier for any QOF clinical targets. The latest QOF points as a percentage of the total available showed the practice to have scored 99% which was higher than the national average of 94.2%.

Specific examples to demonstrate this included:

- Performance for diabetes related indicators was higher than the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average.
- Performance for mental health related and hypertension QOF indicators was better than the national average.
- The dementia diagnosis rate was comparable to the national average.

The practice has a system in place for completing clinical audit cycles. Audits had been revisited and had resulted in improved outcomes for the patients. Examples of audits included various medication audits. Some examples of audits were in response to MHRA alerts such as Domperidone and Valporeate. Audits showed that patients were recalled and some were identified as no longer requiring the medication. For example an osteoporosis audit for patients taking bisphosphonates.

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. Searches on record systems for patients who had long term conditions were carried out continuously so that their condition and medications could be reviewed at regular intervals with the nurses.

Effective staffing

The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety, confidentiality and information governance. There was a staff handbook available. However, some nursing staff told us that their induction had not been sufficient to initially support them in their role and had brought this to the attention of the new practice manager who was in the process of revisiting the induction process for the practice.

Staff received annual e-learning that included:
-safeguarding, fire procedures, and basic life support and information governance awareness. There was a training matrix available which identified which staff had yet to complete their training this year.

The nurses had the opportunity to attend local forums and meetings but we were told that the correspondence about these was often received too late to cancel their clinics and therefore they had not attended as many as they would have liked.

All GPs were up to date with their yearly continuing professional development requirements and they had been revalidated. (Every GP is appraised annually, and

Good

Are services effective?

(for example, treatment is effective)

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). There were annual appraisal systems in place for all other members of staff.

Working with colleagues and other services

Incoming letters from hospitals were scanned onto patient notes and passed onto GPs for action and dealt with on a daily basis. The practice used the patient choose and book and system for referrals to hospitals. More urgent referrals were faxed and followed up by letter.

The practice liaised with other healthcare professionals such as the Health Visitor. The practice also liaised with a multi-disciplinary health care team to discuss patients on their palliative care register.

Information sharing

The practice planned and liaised with the out of hours provider regarding any special needs for a patient; for example faxes were sent regarding end of life care arrangements for patients who may require assistance during the weekend.

The practice had several systems in place to ensure good communications between staff. The practice operated a system of alerts on patients' records to ensure staff were aware of any issues.

Consent to care and treatment

The practice had a Mental Capacity Act Policy in place which described the main points of the Act and a capacity assessment checklist. However, the nurses had not received any training around the Mental Capacity Act 2005 but understood the concepts involved.

We spoke with the GPs about their understanding of the Mental Capacity Act 2005 . GPs demonstrated an awareness of the Act and when best interest decisions needed to be made.

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.

There were consent forms available for minor surgical procedures.

Health promotion and prevention

The practice had 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 various lifestyle management support.

The practice offered a full range of immunisations for children in line with current national guidance. Last year's performance was above local CCG averages for all immunisations. For example, childhood immunisation rates for the vaccinations given to under twos ranged from 96.7% to 100% and five year olds from 93.4% to 97.4%.

Good

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 (from 126 responses) also showed that 77% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 87% said the last GP they saw or spoke to was good at listening to them, which similar to the national averages.

Curtains were provided in consulting 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.

There was a confidentiality policy in place and minutes from staff meetings demonstrated that staff had ensured confidentiality at the reception desk by ensuring patients details could not be overheard.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey showed that 88% said the last GP they saw or spoke to was good at explaining tests and treatments and 77% said the last GP they saw or spoke to was good at involving them in decisions about their care which was in line with the local and national averages. Eighty four percent of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care which again was in line with local and national averages.

The practice participated in the avoidance of unplanned admissions scheme. There were regular meetings to discuss patients on the scheme to ensure all care plans were regularly reviewed.

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. Patients who had been bereaved were sometimes contacted to see if they required any additional support.

Information regarding support for carers was available in the waiting room and alerts were on carer's records to ensure staff could act on any 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 the practice were aware of the challenges of treating an ageing population. The practice had access to community intervention beds to avoid patients attending hospital and attended meetings with multidisciplinary teams to discuss care.

The practice had previously had a patient participation group however there were very few participants. The newly recruited practice manager told us that they had started to advertise for new members and was considering having a virtual group (online meeting) and we could see patients had begun to respond.

Tackling inequity and promoting equality

The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. There was information on advocacy services available for patients.

The building had appropriate access and facilities for disabled people. There was a hearing loop and staff could access sign language services if necessary.

The practice had an equal opportunities policy which was available to all staff on the practice's computer system.

Access to the service

The practice was open between 8.30am to 6.00pm Monday to Friday. The practice operated a mixture of routine, same day and emergency appointments. Appointments could be booked up to four weeks ahead and the appointment system allowed GPs flexibility so they could spend longer with patients if they required more time at an appointment. The practice did not offer any extended hours.

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 was a patient information leaflet available however this needed updating to reflect the change in practice manager.

Results from the GP national Patient survey showed that 76% of patients described their experience of making an appointment as good and that 72% of respondents found it easy to get through to this surgery by phone which was much higher than the local average of 53%.

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. Information about how to make a complaint was available in the waiting room and in a practice leaflet. 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 kept a complaints log for written complaints. There had been seven complaints in the previous twelve months which had been dealt with appropriately and apologies given. Complaints were automatically seen as a significant event and recorded and examined as such to draw out any lessons to be learned.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a mission statement which was on display in the waiting room which read 'To enhance the quality of life of individuals in the local community through the efficient use of health care resources available'.

Comment cards we received were very complimentary about the standard of care received at the practice and confirmed that patients were consulted and given choices as to how they wanted to receive their care.

The practice utilised different support groups which visited the practice on a regular basis including the services of mental health teams and other health care professionals such as chiropodists.

Governance arrangements

There was a governance policy in place which outlined the leadership and governance structure of the practice, staffing, information technology, management, communication and patient participation.

The practice had practice specific 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 the policies were regularly reviewed and in date. The practice manager told us they had recently gone through all policies and updates to these with the staff team.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control. Staff were all clear about their own roles and responsibilities.

The practice had a protocol for whistleblowing and staff we spoke with were aware of what to do if they had to raise any concerns.

The practice manager had recently been recruited and all staff we spoke with had confidence in the practice manager's ability to carry out this role. They told us they had been able to raise any concerns and had begun to see some improvements in the way the practice operated.

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

Results of surveys and complaints were discussed at clinical meetings but information was not always cascaded to the whole team. The practice reception staff encouraged all patients attending to complete the new Friends and Family Test as a method of gaining patients feedback.

The newly appointed practice manager was aware of the need to further engage patients to provide their feedback to drive improvements forward. They had actively been involved in organising more involvement in the patient participation group.

Management lead through learning and improvement

The GP partners and the practice manager met on a weekly basis to discuss business planning and organisational structure. The individual sections of the practice team worked well however much could be done to improve communications so that the whole practice was involved. The new practice manager had been in post for three months and had begun to implement regular staff meetings and recognised communication was a key area for improvement and development of the practice team.

Staff told us that regular appraisals took place and they were scheduled to receive their appraisals for this year with the new practice manager.

The GPs were all involved in revalidation, appraisal schemes and continuing professional development. The GPs had learnt from incidents and complaints and recognised the need to address future challenges. This included succession planning and the practice had already begun the process of recruiting new staff.