The Rose Tree PMS Practice

Quality Report

The Rose Tree PMS Practice
White Rose Medical Practice
The Cudworth Centre
Carlton Street
Barnsley
South Yorkshire
S72 8SU
Tel: 01226 707120
Website: www.whiterosemedicalpractice.nhs.uk

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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 10 December 2014 and the overall rating for the practice was good. The inspection team found after analysing all of the evidence 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:

- The practice learned from significant events and incidents and took action to prevent their recurrence.
- 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 were positive working relationships between staff and other healthcare professionals involved in the delivery of service.

However, we also found an area in which an improvement was needed:

- The practice did not have a patient participation group (PPG).

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 safe. There were standard operating policies and local procedures in place to ensure any risks to patient's health and wellbeing was minimised and managed appropriately. The practice learned from incidents and took action to prevent a recurrence. Medicines were stored and managed safely. The practice building was clean and well maintained and systems were in place to oversee the safety of the building.

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 caring. The patients who completed the NHS Friends and Family test (FFT) 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 and staff supported them in the care they received.

Are services responsive to people's needs?

Good

The practice is responsive. 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 did 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 well led. The practice was meeting people's needs in providing a service where the GPs and nurses had specific lead responsibility for areas of care, for example, safeguarding adults and children. Feedback was sought from patients and complaints were responded to in line with recognised guidance.

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
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. Information was available to carers.

Good

People with long term conditions
There were systems in place to ensure patients with multiple conditions received one annual recall appointment wherever possible. This helped to offer the patient a better overall experience in meeting their needs. Healthcare professionals were skilled in specialist areas and their on-going education meant they were able to ensure best practice was being followed.

Good

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

Good

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

Good

People whose circumstances may make them vulnerable
The practice helped to ensure care for vulnerable people, who may have poor access to primary care was safe, caring, responsive and effective. The practice had arrangements in place for longer appointments to be made available where patients required this and access to translation services when needed.

Good

People experiencing poor mental health (including people with dementia)
The practice helped to ensure care for people experiencing a mental health problem was safe, caring, responsive and effective. The practice had access to professional support such as the local mental health team and psychiatric support as appropriate.

Good

Summary of findings

What people who use the service say

We reviewed 20, NHS Friends and Family test (FFT) feedback forms for December 2014, where patients shared their views and experiences of the service. We also spoke with three patients who were visiting the practice.

Patient comments and feedback from the FFT, told us the staff were courteous, kind and treated them with dignity and respect. They said the staff were understanding and helpful; it was a good practice and it was relatively easy to make an appointment. They felt involved and supported in decisions about their care and were given a caring service.

One patient out of the 20 who completed the FFT said they had received a mixed service. On occasions it had been very good however, they had also experienced lengthy waits when attending appointments.

Responses to the NHS patient survey identified: GPs were good or very good at treating patients with care and concern; patients were involved in decisions about their care, and when they wanted to see or speak to a GP or nurse from the practice, they were able to get an appointment.

Areas for improvement

Action the service SHOULD take to improve

The practice did not have an active patient participation group (PPG).

The Rose Tree 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, a second CQC inspector and a practice manager.

Background to The Rose Tree PMS Practice

The Rose Tree PMS Practice, also known as White Rose Medical Practice has a main surgery at The Cudworth Centre, Barnsley and a branch surgery at Monk Bretton, Barnsley. The branch surgery was not visited on this occasion.

The practice has four (three male and one female) general practitioner (GP) partners, a salaried GP for three days a week, and uses a locum GP one day a week. Working alongside the GPs is a Nurse practitioner/prescriber, (who is also a business partner) a practice nurse, and two health care assistants (all of whom are female). There is an experienced management team including, a business manager/practice manager and administration support/ reception staff.

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 9,000.

The main practice appointment times are Monday 8am – 12md and 1pm – 6pm, Tuesday to Friday 8.30am – 11.30am and 3pm – 6pm. Also advertised on the practice website and in their leaflet, was occasionally appointment times vary to include surgeries between 1pm - 3.00pm to help patients see doctors whilst their children are at school. The branch surgery has specific appointment times to meet the local needs and these are Monday, Thursday and Friday 9am to 11.30am; Tuesday and Wednesday 8.30am – 11.30am.

Weekends, bank holidays and when the practice is closed, urgent healthcare advice that is not a 999 emergency is provided by telephoning the local Out of Hours NHS 111 service, provided by Care UK.

A wide range of practice nurse led clinics 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.

Detailed findings

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.

We carried out an announced inspection visit on 10 December 2014. During our inspection we spoke with staff including a GP who was also the registered manager, the business manager, a clinical nurse specialist, a nurse, a health care assistant and two receptionists/ administration staff.

We spoke with three patients who used the service; observed how patients were being spoken with on the telephone and within the reception area. We also reviewed 20 NHS Friends and Family test (FFT) feedback forms for December 2014, where patients shared their views and experiences of the service.

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

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 with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and 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 year and we reviewed three of these. There was evidence the practice had learned from these and the findings were shared with relevant staff. This was also confirmed by the GP and nurse practitioner. 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 children and vulnerable adults. 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 system and there was an up to date register kept. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. GPs used 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 identifiable and reviewed. The safeguarding lead GP was aware of the vulnerable children and adults on the practice patient register. Records demonstrated there was frequent liaison with partner agencies such as, health visitors and social services and they were easily accessible as they worked from the same building.

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 and this information was recorded on the computerised system. Staff also told us when chaperones were needed the role was carried out by nursing or reception staff who had received 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 weekly checking and advising on medicines that needed regular monitoring and reviewing. They also monitored and audited medicines to ensure the practice followed good practice guidance, published by the Royal Pharmaceutical society and local CCG targets. Quarterly prescribing meetings took place with the CCG and we saw records were kept of the information discussed. The data provided by the CCG showed between October – December 2014 four medicines audits had taken place and in each area the practice was positively responding to guidance and CCG targets.

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 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

Good

Are services safe?

arrangements for managing medicines to keep patients safe and correct procedures were followed for the prescribing, recording, dispensing and disposal of medicines.

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 locked refrigerators. Staff told us the procedure was to check the refrigerator temperatures every day and ensure the vaccines were in date and stored at the correct temperature. We were shown their daily records of the temperature recordings and the desired refrigerator temperatures for storage were maintained.

Cleanliness and infection control:

We observed the premises to be clean and tidy. A cleaning company was employed by the landlord for the building and monitoring of the cleaning 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. We saw evidence the nurse carried out weekly checks on the cleaning logs and this included areas such as, the clinical rooms and equipment.

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. With the exception of one piece of equipment, which had been missed during the testing and therefore was not available for use, the sample of portable electrical equipment we inspected had been tested and was in date.

Staffing and recruitment:

Evidence provided following the inspection, showed recruitment checks were carried out prior to employment. For example, 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. A GP locum had been employed to cover and support where needed and this was currently one day a week.

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 hard copies were kept in their individual folders); 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.

Arrangements to deal with emergencies and major incidents:

There was a business continuity and management plan 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 and how to remotely access the computer systems to contact patients and ensure the continuity of service provision.

We found staff received annual cardiopulmonary resuscitation (CPR) training and staff we spoke with told us

Good

Are services safe?

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 patients 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 at least monthly, 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. There was a Health Trainer at the practice each week, covering areas such as stopping smoking. Health promotion literature was also available and visible in the treatment rooms, the practice waiting areas and was 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.

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). 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. For example, the QOF data showed the practice scored better than average for maintaining a register of all patients in need of palliative care/support irrespective of age, when compared to other practices in the CCG area.

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.

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.

We were told 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.

The practice used long term locum GPs as a support to the practice. There was a 'locum pack' containing local protocols, procedure and guidance for them to follow.

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: safeguarding adults and children and basic life support. Staff also confirmed they received training specific to their roles, for example, chaperone training, vaccinations and immunisation training and this included update training.

Good

Are services effective?

(for example, treatment is effective)

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. The QOF data showed the practice scored better than average (when compared to other practices in the CCG area) for having at least three monthly, multidisciplinary case review meetings where all patients on the palliative care register were discussed.

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. Staff input data such as discharge letters and blood results into the electronic records. Tasks were then sent electronically for the GP to review the information and action as appropriate.

Information sharing:
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 the multi-disciplinary team within the locality. These included palliative care nurses, health visitors, community matron, and district nurses. 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.

Systems were also in place for making referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). We were told by the practice manager that wherever possible, an appointment was made for the patient before they left the practice.

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.

All patients aged 16 – 75 years who requested a consultation and who had not been seen by a GP within a three year period, received a health check as deemed appropriate by the clinician during consultation.

All patients over 75 years had a named GP and received an annual health check. (This consultation took place in the patients' home where in the opinion of the clinician, it would have been inappropriate for them to have attended the practice.) 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 to give parents advice.

The practice web site informed people about 'Self-treatment of common ailments;' and promoted information about how to become healthy. 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, for example a health trainer held a 'Stop Smoking' clinic on a Wednesday afternoon. This had the benefit of providing local, accessible services for patients.

Good

Are services caring?

Our findings

We reviewed 20, NHS Friends and Family test (FFT) feedback forms for December 2014, where patients shared their views and experiences of the service. We also spoke with three patients who were visiting the practice.

Respect, dignity, compassion and empathy:
Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in rooms which gave patients privacy and dignity. Patients at the practice told us they were treated with kindness, dignity, respect and compassion whilst they received care and treatment. They told us they were able to have confidential discussions with staff at reception and there was a room available to talk with staff in private should they choose to.

The NHS GP patient survey showed GPs were good or very good at treating patients with care and concern.

We saw the reception staff treated people with respect and ensured conversations were conducted in a confidential manner.

The practice had a chaperone procedure in place to support patients. There were signs displayed in the practice explaining that patients could ask for a chaperone during examinations if they wanted one. Staff who acted as chaperones were either clinical staff or staff who had received training.

Care planning and involvement in decisions about care and treatment:
The NHS GP patient survey showed GPs were good or very good at involving patients in decisions about their care. The patients we spoke also 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. One person, whose first language was not English, told us how they had been supported through 'Language line' to understand their treatment.

Care plans were in place for patients with specific health needs and these included patients with long term conditions such as, asthma. They were adapted to meet the needs of each individual. This information was designed to help patients to manage their own health, care and wellbeing to maximise their independence and also help reduce the need for hospital admission.

On a Tuesday and Friday afternoons, between 1.30 – 3.30pm a Welfare Rights officer attended the practice and assisted people to fill out forms relating to their welfare.

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 and there was information on the practice web site.

The patients we spoke to on the day of our inspection told us staff were caring and understanding when they needed help and provided support where required. The FFT feedback also confirmed that all of the practice staff were very supportive to them and their families.

Palliative care meetings with clinical staff and community health professionals were held to discuss patient treatment, care and support; this ensured they received co-ordinated care and support.

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. For example, the practice development plan identified a service need in relation to coronary heart disease (CHD), respiratory diseases, and asthma in the under five years age group. In response to this the practice provided clinics for patients with CHD, Chronic Obstructive Pulmonary Disease Clinic (COPD)/Spirometry clinic for patients who have breathing problems, and an asthma clinic.

One of the GP partners told us they were the Medical Director for the Barnsley Clinical Commissioning Group (CCG). As such, they worked there three days a week and engaged regularly with other practices to discuss local needs and service improvements that needed to be prioritised.

Tackling inequity and promoting equality:
The practice leaflet identified their aim, "The practice aim not to discriminate on the grounds of race, gender, age, disability or sexuality." It also stated, "The practice will not tolerate violent or abusive behaviour, and anyone verbally abusing either a member of staff or the public, or using inappropriate language, will be asked to leave the premises and requested to find another GP."

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, a 20 minute appointment would be allocated to a patient who had COPD or diabetes, whilst a 30 minute appointment would be allocated to a patient having a Spirometry test for breathing problems.

Access to the service:
Information was available to patients about appointments in the practice 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.

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

Responses to the NHS patient survey identified patients were either 'Very satisfied' or 'Fairly satisfied' with their GP opening hours. They also stated that when they wanted to see or speak to a GP or nurse from the practice, they were able to get an appointment.

When the practice was closed, urgent healthcare advice was available by telephoning the local Out of Hours NHS 111 service, provided by Care UK.

Repeat prescriptions could be ordered on line, by fax, in person, or by repeat prescription arrangements which are offered by participating pharmacists. The surgery leaflets asked patients to allow 48 working hours' notice before collecting their prescription.

Listening and learning from concerns and complaints:
The practice had 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.

We saw 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 site.

Patients we spoke with were aware of the process to follow if they wished to make a complaint. One person told us when they had complained they were kept informed by the practice and notified as to why there was a delay in the outcome of their investigation.

We reviewed two complaints received by the practice in 2014 and saw they were responded to in line with the practice procedure. We were also told by the practice manager the outcomes of complaints, actions required and lessons learned were shared with the staff during their team meetings where appropriate; this was confirmed by the nursing staff.

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, and were committed to the delivery of a high standard of service and patient care.

Governance arrangements:
The practice had management systems in place. They had policies and procedures to govern activity and these were accessible to staff. We saw the policies incorporated national guidance and legislation.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. It also showed they were achieving in the upper quartile in having regular palliative care meetings, maintaining a register of patient needing palliative care, and those over 18 years of age with a learning disability.

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 and one of the GP partners was the lead for safeguarding. All staff we spoke with were clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Staff we spoke with told us all members of the management team were approachable, supportive and appreciative of their work. They had a proactive approach to incident reporting. Meetings were held and this included those with clinicians, nursing staff, and information was shared with the non clinical staff where appropriate. Staff told us informal meetings also took place. We saw minutes of the formal meetings were held in a hard backed book and located in the advanced nurse practitioners office. Those staff who were not available to attend the meetings were able to refer to the book. We also saw examples of the agenda for those meeting held on the 1st and 8th December 2014. We noted significant events were part of both agendas, as was medicines management. We were told by one of the clinicians that for a period of time GP partner meetings were not taking place, however we were also told these meeting had re-commenced and they hoped they would continue. The practice manager who was responsible for writing the minutes of the meeting said they would in future provide copies of minutes of the meeting for everyone to have.

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:
The practice gathered feedback from patients through the NHS patient survey, comment cards and complaints received. The staff felt they could raise concerns at any time with either the GPs or practice manager, as they were considered to be approachable and responsive. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice did not have an active patient participation group (PPG). However they were looking at ways to develop further links with the community and identify patients who would be willing to form a PPG.

Management lead through learning and improvement:
We saw there was a system in place for staff appraisals and staff had mandatory training and additional training to meet their role, specific needs. Mandatory training included: safeguarding vulnerable adults and children and cardio pulmonary resuscitation training (CPR). 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.