# Parkgate Medical Centre

## Quality Report

Netherfield Lane
Parkgate
Rotherham
S62 6AW
Tel: 01709 514501
Website: www.parkgatemedicalcentre.co.uk

Date of inspection visit: 9 June 2015
Date of publication: 06/08/2015

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

## Ratings

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

# Summary of findings

## Contents

### Summary of this inspection


| | Page |
|---|---|
| Overall summary | 2 |
| The five questions we ask and what we found | 3 |
| The six population groups and what we found | 5 |
| What people who use the service say | 8 |


### Detailed findings from this inspection


| | |
|---|---|
| Our inspection team | 9 |
| Background to Parkgate Medical Centre | 9 |
| Why we carried out this inspection | 9 |
| How we carried out this inspection | 9 |
| Detailed findings | 11 |


## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Parkgate medical centre on 9 June 2015. Overall the practice is rated as good.

We found the practice to be good for providing caring, safe, effective, well-led and responsive services. It was also rated as good for providing services for all population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and managed, including those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Complaints would be addressed in a timely manner and the practice endeavoured to resolve complaints to a satisfactory conclusion.
- Patients said they found it easy to make an appointment with a named GP and 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.
- The practice proactively sought feedback from staff and patients.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**
Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

**Good**

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. 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.

### 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. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles. The practice carried out regular appraisals and put in place personal development plans for staff.

### Are services caring?

**Good**

The practice is rated as good for providing caring services. Patient surveys showed that the practice compared favourably with other practices in the area. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Readily available information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

### Are services responsive to people's needs?

**Good**

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS Area Team and NHS Rotherham Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice, a named GP and continuity of care, with urgent appointments available on the same day. The practice was well equipped to treat patients and meet their needs. The practice had an effective complaints system.

### Are services well-led?

**Good**

The practice is rated as good for being well-led. The leadership team were effective and had a clear vision and purpose. There were

# Summary of findings

systems in place to drive continuous improvement. Governance structures were in place and there was a robust system that ensured risks to patients were minimised. The practice gathered feedback from patients, and it was developing a virtual patient participation group (PPG). 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. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst 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. The practice was responsive to the needs of older people and where appropriate provided home visits.

The practice has 1106 patients on the register who are aged 66 years and over. This represents 18% of the total population. All patients aged over 75 years have been allocated a named GP. The practice have 37 patients in residential nursing and care homes. GPs carry out home visits for housebound patients as required. Home visits are also carried out by members of the wider healthcare team, (e.g. District Nurses, Health Visitors, Advanced Nurse Practitioners). The practices' nurses provide home visits if required.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. Longer appointments and home visits were available when needed. Patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs, the named GP worked with health and care professionals to deliver a multidisciplinary package of care.

The practice provides care for approximately 215 patients on their long term register. Care plans and discussions involving other relevant agencies take place at the monthly multidisciplinary team meetings. The practice has a named GP for long term condition (LTC) patients. These patients are offered longer appointments (30 minutes) for clinic and 30-60 minute appointments for home visits, which are carried out by the lead nurse or a GP.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and those who were at risk. Patients told us, and we saw evidence, that children and young people were treated in an age-appropriate way and recognised as individuals. Appointments were available outside

of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

**Working age people (including those recently retired and students)**

The practice is rated as good for the care of the working age people (including those recently retired and students). The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

**People whose circumstances may make them vulnerable**

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a record of patients living in vulnerable circumstances including homeless people, travellers and those with learning disabilities. The practice offered longer appointments for people with learning disabilities. 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 assists patients with visual impairment to walk from the waiting room to the consulting room if required. The practice keeps a register of patients with learning disabilities, which is reconciled and validated by the Rotherham learning disability team. The practice provides assessments and health checks for patients with learning disabilities.

**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 including those with dementia. The practice had advanced care planning in place for patients with dementia. Staff had received training on how to care for people with mental health needs and dementia.

Services are provided for patients with mental health issues under the Quality and Outcomes Framework. The practice screen patients for dementia. They have a number of Rotherham Doncaster and

# Summary of findings

South Humber (RDASH) mental health team workers attached to the practice, these include: Psychological wellbeing practitioner, talking therapies practitioner and a counsellor. The mental health team work under the improving access to psychological therapies (IAPT) philosophy.

# Summary of findings

## What people who use the service say

We spoke with five patients on the day of our visit. We spoke with people from different age groups, who had different physical needs and had varying levels of contact with the practice. We received 42 completed CQC comment cards. Almost all of these were complimentary about the practice and staff.

The patients were complimentary about the care provided by the staff and their overall friendliness and behaviour. They felt the doctors and nurses were competent and knowledgeable about their treatment needs and the practice provided a professional and efficient service.

Patients reported they felt that all the staff treated them with dignity and respect. Patients told us staff listened to them and were well informed.

Patients said the practice was very supportive and felt their views were valued by staff. They were complimentary about the appointments system, its ease of access and the flexibility it provided.

Patients told us the practice was always clean and tidy.

We reviewed the most recent data available for the practice on patient satisfaction. The evidence from these sources showed patients were satisfied with how they were treated with compassion, dignity and respect. For example, data from the GP patient survey showed 89% of respondents found it easy to get through to this surgery by phone. The local CCG average was 75%.

# Parkgate Medical Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team consisted of a CQC Lead Inspector and three specialist advisors (a GP, practice manager and a practice nurse).

## Background to Parkgate Medical Centre

Parkgate medical centre is registered with CQC to provide primary care services, which includes access to GPs, family planning, surgical procedures, treatment of disease, disorder or injury and diagnostic and screening procedures. It provides GP services for patients living in the Parkgate area of Rotherham.

A branch surgery 'Thorogate Medical Centre' also provides the same service (apart from minor surgery) in the Rawmarsh area of Rotherham was also visited as part of this inspection. The two sites had a single patient list, so patients could be seen at either practice depending on what was more convenient for them. The practice had five GP partners (three male and two female), a management team, practice nurses, healthcare assistants and administrative staff.

The practice is open 8:30am to 17:30pm on Monday to Friday. Patients can book appointments in person, via the phone and online. Appointments can be booked in advance for both the doctor and nurse clinics. When the practice is closed patients can access the out of hours NHS 111 service.

The practice has a Personal Medical Services (PMS) contract. This is the contract between general practices and NHS England for delivering services to the local community.

The practice is part of NHS Rotherham Clinical Commissioning Group (CCG). It is responsible for providing primary care services to just over 6000 patients. The practice is meeting the needs of an increasingly elderly patient list size that is generally comprised of an equal number of women and men.

## Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme covering Clinical Commissioning Groups throughout the country.

We carried out an announced 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 registered 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 in accordance with the Care Act 2014.

Please note 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 CQC at that time.

# Detailed findings

## How we carried out this inspection

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

Before our inspection we carried out an analysis of the data from our intelligent monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We reviewed all areas of the practice including the administrative areas. We sought views from patients through face-to-face interviews. We spoke with GPs, the practice manager, clinical nurses, a voluntary community services advisor, a reception supervisor, administrative staff and receptionists.

We observed how staff treated patients when they visited or phoned the practice. We reviewed how the GP made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Good

# Are services safe?

## Our findings

### Safe track record

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

We reviewed five significant events, safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could evidence a safe track record.

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards were complimentary about the service they had received and raised no concerns about their safety.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events, which had occurred during the last year and these were made available to us. A slot for significant events was on the practice meeting agenda and a dedicated meeting occurred every week to review actions from past significant events and complaints. There was evidence appropriate learning had taken place and the findings were disseminated to relevant staff. Staff including receptionists and nurses were aware of the system for raising issues to be considered at the meetings.

The practice had recently responded to an inappropriate X-ray referral to hospital. The referral was inappropriate due to a recent Royal College of Radiologists (RCR) guideline. This information was communicated throughout the practice to avoid further reoccurrence.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed all staff had received relevant role specific training on safeguarding. We asked members of the medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

The practice had named GPs and nurses appointed as leads in safeguarding vulnerable adults and children; they had received level three safeguarding training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern. In each of the consultation rooms there was a flow chart diagram which included contact numbers for the safeguarding leads. There was a monthly meeting that considered safeguarding incidents with local social services teams.

There was a chaperone policy which was visible at reception. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All staff had been trained to be a chaperone to provide this service.

### Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

There was a dedicated prescription administrator who managed new drugs and repeat prescriptions when letters were received from hospital. Any queries were checked with the duty doctor.

Processes were in place to check medicines were within their expiry date and suitable for use. Medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Patients were routinely informed of common potential side effects at the time of starting a course of medicine. The IT system allowed for ‘on screen’ messages which were discussed with the patient. Side effects of medicines were explained.

Good

# Are services safe?

### Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had nurse leads for Infection Prevention and Control (IPC). They had undertaken further training to enable them to provide advice on the practice IPC policy and carry out staff training. All staff received induction training about IPC specific to their role and had annual updates. We saw evidence the lead nurse had carried out IPC audits for the last year and that any improvements identified for action were completed on time. We saw copies of completed audit reports. The practice had recently obtained the gold standard in IPC.

An infection control policy and supporting procedures were available for staff to refer to which enabled them to plan and implement control of infection measures. Personal protective equipment including disposable gloves and aprons were also available for staff to use.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single-use, and personal protective equipment (PPE), such as aprons and gloves, were available for staff to use. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. We saw training records that showed all staff had received infection control training.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades.

Hand hygiene techniques guidance was displayed in staff and patient toilets. Hand washing sinks with hand gel and hand towel dispensers were available in treatment rooms.

The practice was aware of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We were told the practice carried out regular checks in line with this risk assessment to reduce the risk of infection to staff and patients.

### Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records which confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example spirometer. A spirometer measures the volume and speed of air that can be exhaled and is a method of assessing lung function.

### Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS).

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff received annual appraisals, the staff felt their suggestions were listened to and, where possible, acted upon.

### Monitoring safety and responding to risk

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

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw risks were discussed at GP partners' meetings and within team meetings.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support.

Good

# Are services safe?

The practice had developed a business continuity plan specifying the action to be taken in relation to a range of potential emergencies which could impact on the daily operation of the practice.

The practice did not have emergency oxygen on site. They had a comprehensive risk assessment in place. The neighbouring practice across from the surgery had emergency oxygen.

The practice had carried out a fire risk assessment which included actions required to maintain fire safety. Records showed staff were up to date with fire training.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

Patients' needs were assessed and care and treatment considered, in line with current legislation, standards and evidence-based guidance. We spoke with a GP who told us they used relevant and current evidence-based guidance such as the National Institute for Health and Care Excellence (NICE) guidelines. These were applied during assessment, diagnosis, referral to other services and management of long term conditions or chronic conditions such as hypertension. We did note that some NICE guidelines were not systematically considered so there was a risk of them not all being appropriately implemented. We reported this to the practice manager and GPs on the day of our inspection. The practice were looking at ways in which to avoid this from happening in the future

The GP told us they lead in specialist clinical areas such as diabetes, minor operations, substance misuse, chronic diseases, Gynaecology and mental health. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The GP told us this supported all staff to continually review and discuss new best practice guidelines for the prescribing of medicines. Our review of the clinical meeting minutes confirmed this happened.

The practice coded patient records using specific READ Codes. These are codes which provide the standard vocabulary by which clinicians can record patient findings and procedures in health and social care IT systems. This enabled the GPs to identify patients with long-term conditions and those with complex needs. We found from our discussions with the GPs, in accordance with NICE guidelines, good assessments of patients' needs. For example, the practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. There were regular clinics where patients were booked in for an initial review of their condition; they were then scheduled for recall appointments. This ensured patients had routine tests, such as blood tests to monitor their condition.

Discrimination was avoided when making care and treatment decisions. Interviews with the GPs and nurses showed the culture in the practice was based on the principle that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

**Management, monitoring and improving outcomes for people**

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews managing alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us clinical audits which had been undertaken in the last year. These completed audits enabled the practice to demonstrate the changes since the initial audit. The practice had a system in place for completing clinical audit cycles. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. A recent audit that we saw with regards to hypertension was followed up in February 2015.

The practice also used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients.

Staff were making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked patients receiving repeat prescriptions had been reviewed by the GPs. They also checked all routine health checks were completed for long term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had implemented the gold standards framework for end of life care. It had a palliative care

Good

# Are services effective?

## (for example, treatment is effective)

register and had regular internal and multidisciplinary meetings to discuss the care and support needs of patients and their families. End of life care was also discussed in the monthly practice meeting.

The practice shared prescribing data with the Clinical Commissioning Group (CCG). This was a process of evaluating performance data from the practice and comparing it to practices in the area.

### Effective staffing

Staff had the skills, knowledge, qualifications and experience to deliver effective care and treatment. Staff received appropriate training to meet their learning needs and to cover the scope of their work. The practice was closed every Thursday afternoon for staff training.

Staff we spoke with told us newly employed staff were supported in the first few months of working in the practice. We were able to review staff training records and saw this covered areas such as safeguarding vulnerable adults and children, health and safety, fire and first aid.

The GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated, or had a date for revalidation. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council (GMC) can the GP continue to practice and remain on the performers list with NHS England.

Staff told us they felt they had opportunities to develop and were able to take study leave and protected time to attend courses. Multidisciplinary training and an open supportive culture were evident at this practice.

### Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those patients with complex needs. It received blood test results, x-ray results, letters and discharge summaries from other services, such as hospitals and out of hours services (OOHs), both electronically and by post. We did note that while reviewing some hospital letters, it was unclear why some letters from several months ago had not been recorded as having been viewed and dealt with. Pathology reports however were up to date and clearly all had been dealt with. We reported this to the practice manager and GPs on the day of our inspection.

All staff we spoke with understood their roles and responsibilities when processing information. There were systems in place for these to be reviewed and acted upon where necessary by clinical staff.

The practice had good links with six care homes in the local area. Twice weekly visits were arranged with these care homes and we were told that regular visits reduced the need to make extra appointments from this population group. The practice was also involved in the local CCG care home pilot which would enable one care home to be managed by one GP practice.

The practice worked with district nurses, health visitors and midwives.

### Information sharing

Systems were in place for making referrals through the Choose and Book system. The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

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

### Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing where possible. These care plans were reviewed annually or more frequently if changes in clinical circumstances required it. Staff gave us examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

We saw a copy of a signed consent form for a minor surgery procedure that was undertaken recently.

Good

# Are services effective?

## (for example, treatment is effective)

All clinical staff demonstrated a clear understanding of Gillick competencies. These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

**Health promotion and prevention**

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's practice performance for all immunisations was average for the CCG. There was a clear policy for following up non-attenders, which was undertaken by the named practice nurse.

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

There was a variety of information available for health promotion and prevention throughout the practice; specifically in the waiting area. Information on NHS and support groups was also on display.

The practice offered a range of health promotion and prevention services. These included child immunisation, cervical screening and travel vaccination appointments.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP patient survey tool and feedback from patients undertaken by the practice via the Friends and Family Test. The evidence from these sources showed patients felt they were treated with compassion, dignity and respect. Data from the GP patient survey showed 98% of all respondents said their last appointment was convenient for them. The practice was also above average, at 95%, for its satisfaction scores on patients 'had confidence and trust in the last GP they saw or spoke to'.

Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. We also spoke with patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

We saw the reception staff dealt with patients pleasantly and with sensitivity. They were aware of the need for confidentiality. They ensured conversations were conducted in a confidential manner. Reception staff spoke quietly so their conversations could not be overhead. Patients were offered a private room to speak to reception staff in confidence if they wished.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

**Care planning and involvement in decisions about care and treatment**

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the GP patient survey showed 91% of practice respondents said the last GP they saw or spoke to was good at explaining tests and treatments and 87% said the last GP they saw or spoke to was good at giving them enough time. Both these results were comparable to the local CCG and national averages.

Patients we spoke with on the day of our inspection told us health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff. They had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. In a recent patient participation group (PPG) survey when asked 'Are you entirely satisfied with the service provided by the Practice' 100% responded yes.

Staff told us translation services were available for patients who did not have English as a first language.

**Patient/carer support to cope emotionally with care and treatment**

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

In the recent GP survey, 67% of respondents who wished to see a preferred GP usually got to see or speak to that GP. The local CCG average was 60%.

The practice had recently nominated one of the receptionists to be carers' champion. They actively engage with carers and aim to provide information and support to carers.

A GP gave us an example of the care they provided. The GP was concerned that a patient needed medication and could not travel to the pharmacy by themselves. The GP travelled to the pharmacy with the patient. They then drove the patient home in the GPs own car to ensure they got home safely.

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 people'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.

The NHS Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

There had been three practice managers appointed in the last five years. This had enabled the practice to develop its in house systems so that they were easy to understand and follow. The system of care and accessibility to appointments with a GP of choice was effective. The practice had achieved and implemented the gold standard framework for end of life care.

We were told that GPs sometimes helped in answering the telephones at reception during unpredictable busy times. This enabled good working relationships to be maintained with the management team and meeting the needs of the patients.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to translation services and staff who spoke other languages. The practice provided equality and diversity policies.

The practice had a stable register of patients. The practice manager told us they had a very small number of patients from different ethnic backgrounds, for example Eastern Europeans. The majority of these patients could speak English but interpreting services were available if required, three GPs spoke Hindi, Urdu and Punjabi. The practice had a hearing loop system in place for use by patients with hearing difficulties.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. All consulting and treatment rooms were on the ground floor of the building.

### Access to the service

Appointments were available from 8:30am to 5:30pm on weekdays. Multiple pre-bookable appointments were available up to two weeks in advance. No one was turned away and everybody was seen who turned up on the day. Survey results showed that 89% of respondents found it easy to get through to this surgery by phone as compared to Local CCG average of 75%.

Longer appointments were available for people who needed them and those with long term conditions, learning disabilities and patients that were 'flagged' on the IT system. This also included appointments with a named GP or nurse.

Comprehensive information was available to patients about appointments in reception. This included how to arrange urgent appointments and home visits. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. For example, if patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was also provided to patients.

The practice operated a flexible appointment system to ensure all patients who needed to be seen the same day were accommodated. Patients we spoke with were happy with the appointment system. This ensured patients were able to access healthcare when they needed to. Patients told us they could see another GP if there was a wait to see the GP of their choice. Patients told us when they needed urgent attention they were able to see a GP on the same day.

We did note that availability of appointments for 'working age people' was ineffective. As the GPs were leaving at 6pm, the last bookable routine appointment was at 4.40pm. Although on the day emergencies were seen later that day. Patients could only book 10 working days in advance and the next bookable routine appointment

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

would be for six working days. This would make booking appointments unrealistic in the time frame. We reported this to the practice manager and GPs on the day of our inspection.

The practice used a telephone based system to organise appointments. The practice also catered for urgent 'walk in' cases and people who did not have access to a phone. Reception staff were the first point of contact for patients. They were trained to take demographic data and brief medical details. Patients could be offered a routine appointment, a same day or an urgent appointment.

Patients could book directly into nurse appointments or contacted by reception to book appointments for chronic disease management.

The practice had a practice leaflet which provided information about the services available e.g. counselling services, contact details and repeat prescriptions.

**Listening and learning from concerns and complaints**

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

We saw information was available to help patients understand the complaints system. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

# 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 vision to deliver high quality care and promote good outcomes for patients. We were told details of the vision and practice values were part of the practice's business plan. These values were at the heart of the practice's way of providing services to patients. We did note that there was not a clear leadership or responsibility between the part time senior partner and the management team. We reported this to the practice manager and GPs on the day of our inspection.

We spoke with members of staff who knew and understood the vision and values and knew what their responsibilities were in relation to these.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the IT system. All the policies and procedures we looked at had been reviewed annually and were up to date.

The practice held monthly governance meetings. We looked at minutes from the last meeting and found performance and risks had been discussed. The practice held a comprehensive recovery plan on the IT system which could be accessed via a laptop computer. A 'buddy' arrangement with a nearby GP surgery was in place.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing at the national standards. We saw QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain and improve outcomes.

### Leadership, openness and transparency

We were told that there was named members of staff in lead roles. For example, there was a lead nurse for infection control and the GP was the lead for safeguarding. We spoke with members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GPs fulfilled a leadership role within the practice, providing highly visible, accessible and effective support.

Staff told us they worked in a supportive team and there was an open culture in the practice and were able to freely discuss topics. The also felt they could report any incidents or concerns they might have. This environment demonstrated honesty and transparency at all levels within the practice.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through annual patient surveys, suggestion box and complaints received. We looked at the results of the annual patient survey and were shown reports on comments from patients.

The practice had an established patient participation group (PPG) of eight members which contributed and regularly fedback customer satisfaction. The practice found these comments an extremely useful tool for helping to improve customer service.

The practice manager was working with the PPG to have broader representation from various population groups; including people with a disability. A GP usually attended PPG meetings if required. The PPG met every quarter. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG.

Recent improvements made to the practice as a direct result of the PPG included a digital dash board in reception, improved appointment system and developing the practice newsletter.

Recently a staff member suggested that the nurses required extra support via an administration assistant. This was a demonstration how staff were able to influence change within the practice.

### Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw appraisals took place. Staff told us the practice was very supportive of training.

The practice was a GP training practice and provided a range of clinicians who undertook teaching and assessment of other healthcare professionals. These

# Are services well-led?

Good

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

included qualified doctors and medical students who were undertaking professional education and training courses. At all times the trainees would be supervised by a senior clinician.

The practice offered GPs and the nurses time to develop their skills and competencies. Staff who we spoke with confirmed this study time was made available to them.

We reviewed staff training records and saw staff were up to date with attending mandatory courses such as annual basic life support and safeguarding of children and vulnerable adults. Staff told us they also had opportunities for individual training and development.

The practice completed reviews of significant events and other incidents and shared the learning with the staff team to ensure the practice learnt from incidents to improve outcomes for patients. Significant events and incidents were discussed within weekly clinical meetings and GP meetings.