# Park House Medical Centre

## Quality Report

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Date of inspection visit: 13 January 2015
Date of publication: 23/04/2015

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

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## Overall summary

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

We inspected this practice on 13 January 2015 as part of our new comprehensive inspection programme. This is the first time we have inspected this practice.

The overall rating for this service is good. We found the practice to be good in the safe, effective, caring responsive and well led domains. We found the practice provided good care to people with long term conditions, families, children and young people and people in vulnerable circumstances, older people, working age people and people experiencing poor mental health.

Our key findings were as follows:

- Patients told us they were satisfied with the appointments system and told they could see a GP when they needed to.
- Patients were kept safe from the risk and spread of infection as the provider had carried out audits and acted on their findings
- Patients were treated with dignity and respect and spoken to in a friendly manner by all staff
- Systems were in place to keep patients safe by assessing risk and taking steps to reduce this. We saw evidence of learning from previous incidents.
- Patients, their relatives and carers were involved in all aspects of treatment and their opinions were listened to and acted upon.

**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.

Robust procedures were in place to safeguard children and vulnerable adults from harm. Arrangements were in place to report and investigate any safety incidents. There was an open culture amongst staff which encouraged good communication and learning from these events.

Robust recruitment procedures were in place ensuring all staff had the required checks prior to employment. Arrangements were in place to deal with medical emergencies. Staff had undertaken appropriate training to deal with medical emergencies and emergency medicines and equipment were available and stored securely.

The practice was visibly clean and well maintained. Effective infection prevention and control procedures were in place. Assessments had been carried out to identify and minimise risk of harm to patients and staff using the practice.

**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. We saw that staff had completed an induction programme and had access to continuing training and development.

Patients were referred to specialists when required and GPs had carried out regular audit cycles to monitor the effectiveness of the service.

There were effective systems in place to monitor the health of people with long term conditions and patients who were unable to attend the practice. Links were established with other healthcare providers to ensure the best outcome for patients, including for people with diabetes, poor mental health and patients receiving end of life care.

**Are services caring?**

Good

The practice is rated as good for providing caring services.

Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and

# Summary of findings

treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness, respect and ensured 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 Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP for 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. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

**Are services well-led?**

Good

The practice is rated as good for being well-led.

The practice had a clear vision and a strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the management. The practice had a number of policies and procedures to govern activity and regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). A PPG is made up of patients of the practice who work with staff to improve the service and the quality of care. 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 that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. It was responsive to the needs of older people, and offered an extended appointment for patients over the age of 75 with an emphasis on falls prevention, good balance and posture to help avoid preventable harm from falls. There was evidence to show the practice nurse accessed information from local voluntary agencies to signpost patients to services and information which may support them to maintain good health.

### People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. We saw evidence that the clinicians took proactive steps to ensure that a patient with a long term condition was appropriately diagnosed and treated. Longer appointments and home visits were available when needed. There was a system in place to ensure all patients with a long term condition had a structured annual review to check that their health and medication needs were being met. The practice was performing well in undertaking most of the monitoring required to meet best practice guidelines. However, more proactive steps were needed to ensure that patients with a diagnosis of diabetes with a blood pressure reading of 140/80 or above were recalled and followed up to prevent any deterioration in their health and wellbeing.

For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

### Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard

# Summary of findings

childhood immunisations and the practice performed well in this area. Staff told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. There was a range of information available which was aimed at families, children and young people. There was evidence of joint working with midwives, health visitors and school nurses.

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

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

The 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 that reflects the needs for this age group. For example patients were able to book appointments or order repeat prescriptions online.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and 100% of these patients had received a follow-up to date. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

**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).

# Summary of findings

96% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE, (mental health support charities which aim to provide advice and support to empower anyone experiencing mental health problems). It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

# Summary of findings

## What people who use the service say

We received three CQC comments cards from patients who used Park House Medical Centre and further 23 of the practice's own feedback cards. All 26 cards contained positive comments indicating that patients were happy with the care and treatment they received and felt they were treated with dignity, respect and civility by all staff. Comments indicated that patients felt they received a good service; that patients were given as much time as they needed for consultations and that they were treated holistically and their feelings taken on board. Further comments stated the practice provided excellent care to patients with learning disabilities and was a pleasure to visit. Comments praised the practice weight management programme describing it as inspirational and motivational. Staff were said to be amazing, kind and excellent

Additionally we spoke with six patients on the day of our inspection. All six told us they were able to access appointments when required, they felt they were involved in discussions about their care and were able to make informed decisions.

Patient surveys carried out by the practice PPG in 2012 and 2014 showed that patients were happy with the service provided and felt informed and involved with their care. Analysis of the national GP patient survey by NHS Nottingham North and East showed that the practice had high levels of patient satisfaction for all areas of the service.

# Park House Medical Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector**.** The inspection team included an inspection manager, a GP specialist advisor and a practice manager specialist advisor.

## Background to Park House Medical Centre

Park House Medical Centre is a partnership between two GPs providing primary medical services to approximately 7,200 patients in an area on the outskirts of Nottingham.

The practice is based in a health centre providing a range of specialist services including district nurses, health visitors, midwives, podiatrists, the phlebotomist, a community pharmacy and services supporting people with drug dependence.

Data shows that the percentage of children and older people affected by income deprivation and unemployment is lower than the England average in the practice area. The practice serves a predominantly white British patient population with a fairly even spread of patient age, though a slightly lower number of patients aged 65 and over when compared with the England average.

The CQC intelligent monitoring placed the practice in band 5. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

There are two GP partners who are both male and work full time and two salaried GPs who are both female and work part time. One female salaried GP is currently on long term leave and cover is provided through a male locum. When the practice has a full staff complement they provide 27 GP sessions a week and 6 nurse practitioner sessions.

Patients are offered a choice in terms of the gender of the GP they see. The practice also employs four nurses who are all female and has access to the services of a nurse practitioner, funded through the Prime Minister's Challenge Fund to provide same day access for patients. The clinical team are supported by eight administrative and receptionist staff.

The practice operates from a single location.

The practice holds a Primary Medical Services (PMS) contract to deliver essential primary care services.

This is the first time we have inspected the practice and that is why we included them in the schedule of inspection.

The practice have opted out of providing out-of-hours services to their own patients and there was information on the website and on the practice answer phone advising patients of how to contact the out of hours service outside of practice opening hours.

## Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

# Detailed findings

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.

This provider had not been inspected before and that was why we included them

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

## How we carried out this inspection

Prior to our inspection we reviewed information about the practice and asked other organisations to share what they knew about the service. We also spoke with the staff at a care home who worked closely with the practice.

We carried out an announced comprehensive inspection of this practice on 13 January 2015.

During our visit we spoke with a range of staff (including three GPs; four nurses, the practice manager and five administrative and reception staff). We spoke with six patients who used the service and patient participation group (PPG). The patient participation group are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed three comment cards where patients and members of the public shared their views and experiences of the service and patients had also posted 23 of the practice's own feedback forms in our comments box.

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

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

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

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

Good

# Are services safe?

## Our findings

**Safe track record**

The practice used a range of information to identify risks and improve patient safety. For example, reported significant events and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses but they told us they had not needed to do this.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 3 years. 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 were records of significant events that had occurred during the last 12 months and we were able to review these. Significant events were discussed as part of the clinical meetings and the outcomes and actions needed were recorded. There was evidence that the practice had learned from significant event and that the findings were shared with relevant staff.

The significant events were mainly clinical and none were recorded as being highlighted by reception or administrative staff. We highlighted one significant event which had not been subject to scrutiny. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts (NPSA) were disseminated by email to the clinical staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example there was a recent medicines alert in December 2014 and we saw evidence to demonstrate the practice manager had done a patient search and attached this to the NPSA notification before sending this to clinical staff who contacted all of the affected patients to ensure appropriate action was taken to maintain their safety.

**Reliable safety systems and processes including safeguarding**

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding in January 2015. We asked members of 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 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.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary level 3 safeguarding training to enable them to fulfil this role All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible in the waiting room and in consulting rooms. All nursing staff, including health care assistants had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, a receptionist had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

There was a system for identifying children and young people with a high number of A&E attendances or those experiencing non-accidental injuries and this was

confirmed in the clinical meeting minutes we saw. The GPs could not usually attend child protection case conferences and reviews but sent in reports if they were unable to attend.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

**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 clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice had changed their systems for recording cold chain storage management to ensure there was a clear audit trail demonstrating that vaccines were stored in line with manufacturer's instructions. The practice staff followed the policy.

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

We saw records of clinical meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. The practice identified all patients prescribed a specified anti-depressant and had successfully changed their prescription to a more cost effective medicine by October 2014 without compromising clinical effectiveness and patients outcomes.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed. The nurse told us they could access any training they wanted which was relevant to their role and told us they were attending updates on how to undertake spirometry testing. Spirometry is a test that can help diagnose various lung conditions, most commonly chronic obstructive pulmonary disease (COPD). It can also be used to monitor the severity of some other lung conditions, and their response to treatment.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. These highlighted areas for improvements and the practice clinical teams developed action plans. There were rolling programme of audits for problematic areas of prescribing such as monitoring the use of GTN sprays (a prescribed medicine for patients to use during an angina attack) to ensure patients who needed further investigation were highlighted and to avoid ineffective prescribing and waste.

These medicines audits had produced measurable improvements. For example the practice had implemented CCG wide policy and had undertaken an audit of prescribing of products for patients with an ileostomy or colostomy (a procedure which results in the patient having their bowel attached to their skin.) The aim of the audit was to reduce waste in prescribing. The practice has also completed an audit of use of gluten free products. Changes had been successfully implemented and patients had accepted the prescribing changes, suggesting the education of patients had been effective and they understood the reasons for the changes.

The practice had audited the medicines prescribed to patients at a local intermediate care service to ensure effective prescribing when patients were discharged from hospital. As a result of the audit there had been changes to hospital discharge prescribing procedures and the GPs were assured that patients were prescribed the most appropriate medicines to meet their healthcare needs.

All prescriptions whether acute or repeat prescriptions (if requested early) were reviewed and signed by a GP before they were given to the patient. There was a system in place to ensure that patients signed for controlled drugs. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Good

# Are services safe?

The practice held a central stock of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) which were controlled and managed by the practice nurses. There were standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely by the nurse. There were arrangements in place for the destruction of controlled drugs. The GPs told us they used very few controlled drugs in emergency situations.

We looked in two doctor's bags and saw there was an appropriate stock of suitable medicines which a GP may need to provide given the practice demographic and geography. The medicines were all in date. The GPs took responsibilities for checking their bags and ensuring they were appropriately stocked and in date.

The nursing staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

**Cleanliness and infection control**

The premises are cleaned by the contract cleaners and all cleaning products, details of CoSHH and product data sheets were stored in a locked cupboard. However the provider may wish to note that the cupboard was left unlocked during office hours and locked at night. Whilst the cupboard was in a staff only area, it may still be accessible to patients.

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept, these were consistently completed. Patients we spoke with told us they always found the practice spotless. Patients did not raise any concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. The practice nurse had a thorough system in place to ensure she was up to date with current guidance and best practice.

All staff received induction training about infection control specific to their role and received follow on e-learning annually. We saw evidence that the lead had carried out audits for each of the last two years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

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

**Equipment**

Staff we spoke with told us they had enough equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs which were completed by the NHS property services and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date of August 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and the sphygmomanometer (for testing patients' blood pressure) to ensure that the readings were correct.

**Staffing and recruitment**

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate

professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw the partners had increased clinical staffing to cover an extra clinical session. We saw 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. Newly appointed staff had this expectation written in their contracts.

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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

**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. The landlord of the property took responsibility for maintenance of the premises including the environment. The practice staff took responsibility for checking the effectiveness of medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Practice staff could articulate the risks they felt there were for patients, staff and visitors but there was no risk log or register in place. There had been a reception support assessment undertaken which assessed all areas of the practice reception.

We spoke with the staff about the main risks identified for the practice. Several of the GPs highlighted one of the greatest risk was lack of space for expansion given the growing patient list. Also the increased likelihood of patients using the urgent care services based at the health centre wanting to register with the practice. This led to concerns about demand management.

Where health and safety risks were identified, each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed with GPs within team meetings.

**Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all nursing staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice with a copy on the hard drive along with paper copies held by three members of staff. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. There was a disaster plan displayed in the reception area for all staff to access.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The practice were flagging as an outlier for the percentage of patients aged 75 or over experiencing a fragility fracture and not being treated with a bone-sparing agent. An outlier means the data is significantly different when compared to other practices. The clinical leads were aware of this data and we looked at the reasons for this and the numbers of patients involved were very small. In addition the practice staff had proactively undertaken a clinical audit on vitamin D deficiency screening, diagnosis and treatment which had resulted in improved outcomes for patients. Vitamin D is important in maintaining good bone health.

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners using standard QOF data and they also accessed the internet. QOF is a national recording system used to monitor the performance of GP services in a number of areas. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and in the majority of cases these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as long term conditions, weight management and contraception. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines. Our review of the clinical meeting minutes confirmed that this happened.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, they performed well on medicine of choice which was comparable to similar practices. The practice were auditing a number of areas of prescribing with the medicines management team from the CCG. The volume of antibiotic prescribing was higher than the CCG average but on the available evidence our clinical experts identified this was likely to be due to better same day access to the service resulting in more responsive prescribing. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We sampled a selection of these and they enabled care and treatment to be co-ordinated in most cases.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients who may have cancer under the two week wait. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

**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, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits, meetings and significant event analysis.

The practice showed us 15 clinical audits that had been undertaken in the last 12 months. 13 of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit.

The GPs told us clinical audits were mostly linked to medicines management information, but we saw the practice had undertaken a clinical audit on vitamin D deficiency screening, diagnosis and treatment. This had been done following an issue raised by one of the nurses who had seen a patient with a vitamin D deficiency. Following the audit, the practice put an action plan in place to ensure that this issue was handled in line with best practice guidelines. GPs maintained records showing how

Good

# Are services effective?

## (for example, treatment is effective)

they had evaluated the service and documented the success of any changes. In this case there were measurable improvements in the rates of diagnosis, successful treatment and ongoing monitoring.

The practice also used the information collected for the QOF. QOF is a national recording system used to monitor the performance of GP services in a number of areas. and performance against national screening programmes to monitor outcomes for patients. For example, the practice met all the minimum standards for QOF in asthma/ chronic obstructive pulmonary disease (lung disease) and for palliative care. This practice was an outlier for QOF in two areas detailed above.

The team was 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, as a group, 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. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had implemented standards for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable or better in most areas to other services in the area. For example one of the partners had undertaken a peer review on weight management. As a result of which practice patients longer term outcomes for achieving a maintaining weight loss were better than the CCG average and the success rates of private weight management companies.

**Effective staffing**

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses the practice considered mandatory such as annual basic life support. We noted a good skill mix among the doctors with one having an interest in sexual and reproductive medicine, and one with a special interest in weight management. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses for example reception staff were able to look at a range of training courses and undertake e learning as needed. The practice had a locum in place covering a salaried GP's absence. They told us the practice staff were friendly, approachable and supportive and had arranged for him to have a training session on SystmOne before he started working at the practice.

The practice held support meetings for receptionists monthly and the agenda was based around the training and support needs of reception staff and action plans were developed to meet these.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, administration of vaccines, cervical cytology and spirometry. Those with extended roles were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Good

# Are services effective?

## (for example, treatment is effective)

### Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. There was no protocol in place to guide reception staff in deciding what documents should be seen by the GP to ensure consistency of approach. Reception and clinical staff read and acted on any issues arising from communications with other care providers on the day they were received.

The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There was one instance within the last year of any results not being followed up appropriately, but this was identified and highlighted. A significant event analysis was carried out and actions were highlighted to prevent this happening again.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, in particular those with long term conditions. These meetings were attended by district nurses, palliative care nurses, respiratory nurse, and nursing from various clinical specialities. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice supported an intermediate care service locally and held a, "ward round" at least twice a week, staffed by GPs on a rotational basis. They were looking to improve continuity for patients by doing a month on, month off rota.

### Information sharing

The practice used SystmOne to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be sent and received in a secure and timely manner**.** Electronic systems were also in place for making referrals, and the practice made 75% of referrals last year 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). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational in the near future. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record SystmOne 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 that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 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. We observed an example of a parent asking for information about their older child which practice staff were not able to provide. We observed they demonstrated in their response an understanding of Fraser guidelines and the Caldicott principles (this covers the principles of sharing information without the patient's consent) and handled the situation with diplomacy.

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. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. For example, we looked at the care plans for four patients with complex needs. All four showed evidence of annual review. Two, one for a patient with learning disabilities and one with dementia, showed the patients best interest, capacity to consent and communication

Good

# Are services effective?

## (for example, treatment is effective)

needs had been assessed. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). There was a practice policy for documenting consent for specific interventions.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

**Health promotion and prevention**

There was a wide range of health promotion information available in the reception area. This was grouped on boards and focussed on the needs of particular population groups. For example there was information targeted at patients experiencing; mental ill health, regarding sexual health, information about smoking cessation, cancer, oral health and prescriptions.

It was practice policy to offer a health check with the nurse or healthcare assistant 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.

The practice also offered NHS Health Checks to all its patients aged over 75. Practice data showed that of the 441 patients in this group 88 (21%) of patients in this age group took up the offer of the health check. We saw that the practice nurse had identified that the majority of these patients were concerned about falling. The nurse had developed a range of exercises to help improve patient's strength and balance and thereby reduce the risk of falls. A GP showed us how patients were followed up if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. There were 25 patients on the register and all were offered an annual physical health check. Practice records showed 22 had received a check up in the last 12 months.

The practice had also identified the smoking status of 86% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 87%, which was better than others in the CCG area and much better than the national average. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited annually patients who do not attend. There was a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance and the uptake of flu vaccinations was in line with the national average. The practice had the highest rates for childhood immunisations of any practice in the CCG area. We saw an effective system was in place to monitor the immunisation status of all children registered with the practice and to actively follow up non-attendance.

We saw that patients over the age of 75 and those with long term conditions had access to a named GP and that multi-disciplinary meetings to discuss the care of patients with complex need were held.

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 national patient survey and a survey of 186 patients undertaken by the practice's patient participation group (PPG). The evidence from both of these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated slightly above the national average for patients who rated the practice as good or very good. The practice was slightly below the CCG average for its satisfaction scores on consultations with doctors and nurses with 83% of practice respondents saying the GP was good at listening to them and 89% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 26 completed cards all were positive about the service experienced. Patients said the staff and doctors were excellent, helpful, friendly, kind and they told us the service, care and treatment were excellent. There were 23 patients who completed family and friend test questions and placed these in our comment card boxes. Of these, 19 patients said they would be "extremely likely" to recommend the GP practice to family and friends and the remainder said they were likely to do so. We also spoke with six patients on the day of our inspection. They 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 that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. There was a privacy line in use at the reception area, and the practice switchboard was shielded by glass partitions which helped keep patient information private. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

For example we observed a telephone conversation between a member of reception staff and a patient. Although the conversation appeared difficult, we noted that throughout the conversation the staff member behaved in a calm and respectful manner at all times. We saw that they showed great understanding of the data protection act and Caldicott principles. Caldicott principals is the name given to a list of recommendations aimed at improving the way the health and care handle and protects patient information. It was noted that the staff member ensured patient data was kept safe and the caller was dealt with sympathetically and respectfully.

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

The most recent data demonstrated that the practice had slightly higher than the national average number of patients with a diagnosis of dementia who had been reviewed in a face to face meeting within the previous 12 months. They were meeting all of their performance data for those patients requiring care plans.

The patient survey information we reviewed showed patients responded positively and in line with national expectations on questions about their involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 85% of practice respondents said the GP involved them in care decisions and 87% felt the GP was good at explaining treatment and results. Both these results were broadly in line with local CCG and national results. The results from the practice's own satisfaction survey and our findings during our inspection showed that the majority of patients said they were sufficiently involved in making decisions about their care.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Patients told us information was given in a way they understood and options and outcomes discussed were realistic. They also told us they felt listened to and

Good

# Are services caring?

supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and patients indicated GPs gave patients time and involved them in decisions.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

**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. The patients we spoke to on the day of our inspection and the comment cards we received showed that patients were happy with the support they received and access to care.

Notices in the patient waiting room and patient website also signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. This information was also displayed in the waiting area and on the practice website.

Staff told us families who had suffered bereavement were called by the practice. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and signposting to a bereavement support service.

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 in the way services were delivered.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged with them and other practices as needed 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 particularly in relation to medicines management.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG).

The practice maintained a register of patients with a range of long term conditions. Data we saw demonstrated that the practice performed in line with the national average in most areas of monitoring in relation to patients with a diagnosis of diabetes. However, the practice was below the national average for the percentage of patients diagnosed with diabetes with a blood pressure reading within the previous 12 months of 140/80 or lower. This would be significant as maintaining a lower blood pressure has been demonstrated to have positive health benefits to patients with diabetes.

We looked at the reasons for this. The nurse told us there were difficulties getting patients to return for follow up blood pressure tests for a variety of reasons including patients' working hours and parking difficulties.

**Tackling inequity and promoting equality**

The practice had recognised the needs of different groups in the planning of its services.

The practice staff recognised that the majority of their patients were below 65. They understood and assessed the needs of patients with a learning disability and had identified those experiencing mental ill health. The practice staff had identified concerns about access to secondary care and support services for people experiencing a mental health crisis. We were told these concerns had been raised with the CCG but no further action had been taken.

The practice had access to online and telephone translation services should this be required. There was also a touch screen arrival system which could be translated into a variety of languages. The patient population were mainly white British with English as their first language. The practice could cater for other different languages through translation services.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

The premises were purpose built and services had been adapted to meet the needs of people with disabilities including providing level access, a vertical lift with low level buttons and call alarms. The practice had provided turning circles in the wide corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

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

**Access to the service**

Appointments were available from 08:30 am to 6 pm on weekdays with a same day appointment available with a nurse practitioner three days a week.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

Following a significant event the clinical team had made the decision to extend appointments from 10 minute slots. Patients were able to have longer appointments if they needed them. Home visits were made to a local care homes providing intermediate care at least twice a week.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

**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 that information was available to help patients understand the complaints system a poster was displayed in the reception area, the process was also explained in the patient leaflet and on the practice website. This included an easy to understand flowchart explaining the process for patients. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at five complaints received in the last 12 months. Two had been analysed as significant events. These were handled effectively and dealt with in a timely open and transparent manner.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and shared with the practice team.

# Are services well-led?

Good

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

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