# Parsons Heath Medical Centre

## Quality Report

35a Parsons Heath
Colchester
Essex
CO4 3HS
Tel: 01206 864395
Website:
www.parsonsheath.co.uk

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

# Summary of findings

## Contents

# Summary of findings

## Overall summary

Parsons Heath Medical Centre provides primary care services for approximately 11,000 patients in Colchester.

The regulated activities we inspected were diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.

We spoke with patients and carers on the day of the inspection. Every response was complimentary and positive about the service provided. We spoke with members of the Patient Participation Group (PPG) and they told us they felt the practice listened to them and actions that were identified were acted on.

The practice was providing safe care. The practice learned from incidents, complaints and patient feedback and took action to improve to ensure safe patient care.

The care and treatment provided to patients was effective. There was evidence of clinical audits taking place to ensure positive clinical outcomes for patients.

The service was caring with all staff displaying a positive attitude towards patients and their care and treatment.

The service was responsive to patients' needs. Complaints were investigated and responded to and lessons were learned to improve practice.

The service was well-led. There were visible and responsive leaders and a culture of openness where all staff felt valued, respected, able to express their views and be heard. All practice staff had shared vision and values and there was an expectation of high standards of patient care.

We looked at how services were provided for specific groups within the population. These were, vulnerable older people (over 75), people with long-term conditions, mothers, babies, children and young people, working age population and those recently retired (aged up to 74), people in vulnerable circumstances who may have poor access to primary care, and people experiencing a mental health problem. We found that the practice had adequate arrangements to look after the needs of the patients in these groups.

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

The service was safe. We found that systems were in place to address incidents, deal with complaints and protect adults and children who used the service. Patients we spoke with told us they felt safe. We saw recruitment systems were in place which ensured most checks were made on staff before they were employed. These checks helped determine if were suitable to work with vulnerable people.

**Are services effective?**

We found the service to be effective. Care and treatment was delivered in line with current best practice. and the practice regularly met with other health professionals and commissioners in the local area. Clinical audits were undertaken on a regular basis and results from those audits were used to improve the quality of services provided. There were staff with the right skills and experience and we saw robust processes in place to ensure staff were developed in their role.

**Are services caring?**

The service was caring. Patients we spoke with during our inspection were complimentary about the service. In particular we were told that patients felt more than just well cared for and that staff were considerate, friendly and attentive to their needs. We observed positive interaction between staff and patients and patient experience surveys showed a high degree of satisfaction with the service provided. Patients who were identified and receiving palliative care had a named GP who took responsibility for end of life care. There were systems in place for the practice to give support to the family in times of bereavement.

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

The service was responsive to people's needs.There was a culture of openness throughout the organisation and a clear complaints policy. The practice acted on patients' suggestions for improving the service. The practice had an active Patient Participation Group (PPG) that was fully involved with decision-making. The PPG is a group of patients registered with the surgery who have no medical training but have an interest in the services provided. The practice participated actively in discussions with the Clinical Commissioning Group about how to improve services for patients in the area. We found that the practice understood the needs of its population and

# Summary of findings

made reasonable adjustments according to the individual needs of patients. There was collaborative working between the practice and other health and social care services which helped to ensure patients received the best outcomes.

**Are services well-led?**

The service was well led. There were clear lines of management and the vision and purpose of the service was shared by all staff. Governance structures were robust and there was a system in place for managing risks. There was a Patient Participation Group (PPG) which believed that its views were listened to and acted on.

# Summary of findings

## The six population groups and what we found

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

**Older people**
The practice was responsive to the needs of older patients and carers. The practice encouraged older people to attend the practice for a health check and have the flu vaccination. The practice had improved the information it produced for patients about the referral process and told us this had been particularly helpful for some older patients and carers. The practice had established links with local care homes.

**People with long-term conditions**
The practice cared effectively for people with long term conditions. The practice was performing in line with national and local targets for a range of conditions. The provider made clinical staff aware of alerts about relevant guidelines.The review dates of patients with some long-term conditions such as heart disease, chronic breathing problems and stroke were monitored to ensure their health needs were regularly considered.

**Mothers, babies, children and young people**
The practice employed a dual-trained nurse/midwife; they were able to offer midwifery clinics twice a week.The practice offered a range of services for mothers and babies and was meeting national targets in relation to primary care services for children. Staff understood their responsibilities in relation to safeguarding children and acted when they had concerns.

**The working-age population and those recently retired**
The practice offered extended surgery hours on two mornings each week from 6.45am to 8am. This was useful for patients who worked during the day. Patients could also request to have a GP a call them back for a telephone consultation to identify if they need to attend the surgery.The adult health-screening programme for people aged between 40 and 75 had been introduced and the practice manager informed us that the patients had responded positively to these health checks.

**People in vulnerable circumstances who may have poor access to primary care**
The practice had identified patients with learning disabilities. There was evidence of effective partnership working with the social care

# Summary of findings

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| team for people with learning disabilities which also offered support for carers. The practice told us that their patient population group did not include significant numbers of other people in vulnerable circumstances. | |
| **People experiencing poor mental health**<br>The provider worked with community psychiatric nurses and a local psychological therapy service to help ensure that people received the necessary care and support. | |

# Summary of findings

## What people who use the service say

All the patients we spoke with during the inspection were highly complimentary about the service they received. They told us that they felt they were respected and well cared for. People described the staff and doctors as excellent. Patients also told us that they felt involved in decisions about their care and treatment, and that they were treated with dignity and respect.

We collected 11 comment cards from a box we left in the surgery in the week before our visit. All the comments on the cards were very positive.

Only a few of the patients we spoke with were aware of the complaints procedure. The complaints procedure was not on display in either waiting areas, although an information sheet was available on request from reception.

# Parsons Heath Medical CentreParsons Heath Medical Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC inspector and a GP. The team also included another experienced CQC inspector, a specialist advisor with a primary medical care background and an expert by experience who helped us to capture the experiences of patients who used the service.

## Background to Parsons Heath Medical Centre

Parsons Heath Medical Centre provides a range of primary care services for just over 11,000 patients in the Parsons Heath area of Colchester. Parsons Heath Medical Centre is a GP training practice and they had two GP registrars whose training was being overseen by an experienced GP. GP registrars are fully qualified and registered doctors who are on a three year GP registration course.

There were three care homes located within the medical practice's area to which the GPs provided a service. All three homes informed us that they received an excellent GP service.

## Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our future approach to inspecting GPs. This provider had not been inspected before and that was why we included them.

## 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?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

# Detailed findings

Before inspecting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service.

We carried out an announced inspection on 04 June 2014.

During our inspection we spoke with a range of staff and patients who used the service. We observed how people were being cared for and talked with patients, their carers and family members. Before our inspection we left comment cards for patients to complete. We looked at the completed comment cards left by patients who used the service in the week before our inspection. We reviewed national patient surveys and the practice's own patient survey.

# Are services safe?

## Summary of findings

The service  was safe. We found that systems were in place to address incidents, deal with complaints and protect adults and children who used the service. Patients we spoke with told us they felt safe. We saw recruitment systems were in place which ensured most checks were made on staff before they were employed. These checks helped determine if were suitable to work with vulnerable people.

## Our findings

### Safe patient care

We found that there were systems in place for reporting issues and concerns which may pose a risk to patients and staff. There was a robust system for reporting significant events and regular audits took place by clinicians to explore the effectiveness of care and whether changes in process were necessary.

The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. There were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). These alerts contain safety and risk information regarding medication and equipment. We saw that all MHRA alerts received by the practice had been actioned and completed. There were also arrangements for reviewing and acting on National Patient Safety Agency (NPSA) alerts. These are alerts that are issued to help reduce risks to patients who receive NHS care.

### Learning from incidents

There were arrangements in place for reporting safety incidents. The practice held fortnightly clinical practice meetings which were attended by the clinical staff and the practice manager we saw minutes from these meetings that confirmed actions identified were actioned. Any incidents or complaints were documented and discussed at these meetings. The practice manager captured the learning in an action plan and ensured actions were followed up. Administrative staff reported incidents directly to the practice manager and staff members told us they were encouraged to report incidents.

Staff were aware of their role in reporting incidents and how to make a report. We reviewed a number of recent examples, including a ‘near miss’ involving a vaccination which was almost administered to a patient in error. We saw evidence that this incident had been discussed and learning points documented and shared with staff. The practice could show that it had implemented changes to reduce the risk of recurrence

We saw that patient safety incidents had been reported in line with NHS National Patient Safety Agency (NPSA) guidelines. We saw evidence that learning consistent with the National Framework for Reporting and Learning from

# Are services safe?

Serious Incidents had taken place. We found that lessons learned from incidents had been implemented. For example in the case of a medicine error, checks had been acted upon to reduce the chance of reoccurrence.

## Safeguarding

The practice had clear safeguarding policies and procedures in place to protect vulnerable patients. There was a named clinical (GP) lead for safeguarding. The named lead provided guidance and training to all staff during their induction and reviewed this annually. We saw evidence in the training records that such training took place and the dates refresher training was due to take place. We saw a selection of training certificates which showed that staff had received safeguarding training at the appropriate level for their role.

Staff we spoke with knew how to recognise different types of abuse and the action they should take if they suspected abuse. Staff were aware who, in the practice, the safeguarding lead was. The staff we spoke with were familiar with the procedure for referring safeguarding concerns to the local authority. We saw this information was clearly displayed in the communal areas.

## Monitoring safety and responding to risk

Staffing levels were continuously monitored to ensure levels of staff present met patient need and minimised risk. We saw evidence of how appointment trends were monitored and staffing levels adjusted to meet changes in demand. This was carried out on a weekly basis. At the time of our visit, the practice had two locum GPs to replace a partner who had taken early retirement. This ensured minimal delays to patient appointments.

There was a defibrillator and oxygen available for use in a medical emergency. We saw records which demonstrated the equipment was checked daily to ensure it was in working condition. The staff rota showed the provider ensured there was always a duty doctor or practice nurse available to deal with any medical emergencies.

The practice had an emergency call icon on all computers. In the event of an emergency this icon was activated. This alerted staff in other parts of the building to the emergency and requested them to respond to it.

## Medicines management

There was a clearly written protocol for managing prescriptions in place. We observed the process involved in issuing prescriptions and found this was safe and that essential checks were made at every stage. We reviewed the arrangements in place for repeat prescriptions. The practice ensured that people received their medicines when they needed them. This included requests for medicines made at short notice. Patients on multiple medicines over a period of time received a six-monthly medication review to reduce the risk of side effects and complications.

The practice stored medicines safely including vaccines, stock medicines and patients' own medicines.. The practice ensured that the correct temperature was maintained for the storage of temperature-critical medicines. There were set procedures for staff to follow should the fridge temperature deviate from the accepted range and put the integrity of stored vaccines at risk. Prescription pads were also monitored and stored securely.

## Cleanliness and infection control

We saw the practice was clean and organised. Patients we spoke with said they were satisfied with standards of hygiene. There were systems in place to reduce the risk and spread of infection. We observed, and staff told us, that personal protective equipment was readily available. Patients confirmed staff wore personal protective equipment when needed. Hand sanitation gel was available for staff and patients throughout the practice. We saw staff used this. We saw hand washing posters above each wash hand basin throughout the practice including in the patients' toilet.

The premises were cleaned daily to a set schedule. We read an infection prevention control policy that showed the surgery had a nominated infection prevention control lead staff member. The policy covered communicable diseases, dealing with spillages, inoculations, blood borne illnesses, handling samples, clinical waste, management of sharps and basic hand washing. The policy identified a safe procedure for obtaining, storing and transporting samples. We discussed several different policies with the staff and they confirmed they used the most recent guidance.

## Staffing and recruitment

We were shown how the practice ensured there were sufficient numbers of suitably qualified, skilled and experienced staff employed each day. We were told how staffing levels had been managed through a rota system. We saw rotas were in place for reception and nursing staff. A GP duty rota was also in place. This showed the practice had monitored and reviewed their workforce requirements

# Are services safe?

to ensure sufficient staff were available to meet the needs of the population they served. The practice manager confirmed they had sufficient staff on duty throughout the week.

We looked to see what guidance was in place for staff about expected and unexpected changing circumstances in respect of staffing. We saw a selection of policies and procedures in place, for example, staff sickness, and planned absences. We saw how the practice would ensure staff absence was managed in a fair and consistent way to ensure the impact on the service provided was minimised.

We saw how if a shortfall of GPs ever occurred, for example, as a result of sickness, locum GPs would be used. We were shown the business continuity plan which had been adopted by the practice which advised what to do should there be 'Incapacity of GPs and practice staff'. This would help to ensure sufficient availability of GPs to continue to provide a service to patients.

The practice had a comprehensive and up-to-date recruitment policy in place. The policy detailed all the pre-employment checks to be undertaken on a prospective member of staff before that person could start work at the practice. This included evidence of identification, references and a criminal record check with the Disclosure and Barring Service (DBS). We looked at a sample of recruitment files for the GPs, administrative staff and nurses. They demonstrated that the recruitment procedure had been followed.

### Dealing with Emergencies

There were clear policies and contingency plans in place for ensuring business continuity in the event of an emergency situation. This highlighted situations which would present risks to patients and the practice such as computer system failure, telephone breakdown, loss of utilities or floods. The policy stated who would be responsible for ensuring action was taken to ensure the practice could continue to serve patients; the timeframes for response and the arrangements for evacuation and accessing alternative premises.

The practice manager told us they were a member of a practice consortium and the practice manager had established positive links with other practice managers to enable and facilitate support in emergency situations. Staff we spoke with knew where the policies were kept and they told us they could access them easily. The staff contact list was fully completed this ensured each person could be contacted in emergency situations.

### Equipment

There were policies in place for the safe use and maintenance of equipment and we were also shown the provider's maintenance schedule. All portable electrical appliances had been tested and the chair lift in the main practice had been appropriately maintained. Fire safety equipment and alarms had been regularly checked for good working order, and there was evidence that a fire evacuation drill had been carried out.

# Are services effective?

(for example, treatment is effective)

## Summary of findings

We found the service to be effective. Care and treatment was delivered in line with current best practice. and the practice regularly met with other health professionals and commissioners in the local area. Clinical audits were undertaken on a regular basis and results from those audits were used to improve the quality of services provided. There were staff with the right skills and experience and we saw robust processes in place to ensure staff were developed in their role.

## Our findings

### Promoting best practice

Patients' needs were assessed and care and treatment was planned and delivered in line with their individual needs. All patients we spoke with were very happy with the care they
received.

Staff were encouraged to keep their professional skills and knowledge up-to-date. For example, the clinical staff were aware of and followed current national guidelines on antibiotic prescribing. One patient told us that the GP had explained to them why antibiotics were inappropriate for a viral infection. They had found this explanation helpful.

The practice followed national and locally agreed policies for referrals, for example, referring patients with cancers within two weeks. The practice had an electronic referral template in place. This enabled the GPs to systematically obtain and assess the information needed to make a referral to the appropriate specialist. The practice employed two medical secretaries whose role included assisting clinicians and patients with the referral process.

We saw that the practice carried out regular clinical audits. We were shown some clinical audits that had been completed and repeated; this ensured actions put in place had made a difference to the outcomes for patients .We found the monitoring the practice had carried out included chronic conditions and how the practice was organised. Some of this monitoring was carried out as part of the Quality and Outcomes Framework (QOF). This is an annual incentive programme designed to monetarily reward doctors for implementing good practice. The practice demonstrated they were meeting the expected targets.

The practice was able to identify and take appropriate action on areas of concern. For example, the practice told us they had a large number of referrals for orthopaedic treatment, but had identified this was due to a large elderly population within the area.

### Staffing

There were effective induction programmes for new staff. The practice was a training practice for fully qualified doctors to gain experience and higher qualifications in

# Are services effective?

## (for example, treatment is effective)

general practice and family medicine. There was a comprehensive induction programme in place that followed national guidelines to support new doctors into the practice.

The learning needs of staff were identified and training put in place to ensure patients received appropriate care and treatment. The practice maintained a training log for all staff which identified what training had been completed and when it was due to be updated. Where staff had identified the need for additional training, specific to their role or for their professional development, they had been supported to access this. Each month staff received additional training as outlined in a training schedule. We saw that this time was protected to enable all staff to attend.

There were systems in place that ensured appropriate levels of supervision and appraisal of all staff. All the staff we spoke with informed us that they received an annual appraisal which they found supportive and effective in helping them to identify and meet their learning needs. GPs were supported in their revalidation through an appraisal system. Revalidation is the process by which licensed doctors are required to demonstrate that they are up to date and fit to practise. Supervision of staff was provided on a one to one basis when needed and through structured meetings. These included; daily peer review between GPs: weekly meetings between the GPs and practice manager to discuss the general running of the service; monthly meetings between the GPs and the nursing team and monthly team meetings for all members of staff to attend.

### Working with other services

The practice worked effectively with other services. There were clear referral pathways and the practice was able to refer people to a wide range of specialist services available in the local area. Staff described having positive relationships with community health professionals, for example, health visitors who led a weekly baby clinic on the premises. The doctors also ran a monthly multidisciplinary team meeting to discuss the progress of patients with complex needs. This was attended by practice staff, community health staff and specialist consultants as appropriate.

### Health, promotion and prevention

The practice promoted patients' health and wellbeing. There was a wide range of posters and leaflets in the waiting area although most of this information was only in English. All new patients received a health check and advice. The practice participated in national population and child health screening and immunisation programmes.

The health care assistant's role included health promotion and they provided advice for patients on lifestyle factors such as smoking and diet. The doctors and practice nurse told us they provided opportunistic health promotion advice during consultations whenever this was appropriate.

# Are services caring?

## Summary of findings

The service was caring. Patients we spoke with during our inspection were complimentary about the service. In particular we were told that patients felt more than just well cared for and that staff were considerate, friendly and attentive to their needs. We observed positive interaction between staff and patients and patient experience surveys showed a high degree of satisfaction with the service provided.

Patients who were identified and receiving palliative care had a named GP who took responsibility for the end of life care. There were systems in place for the practice to give support to the family in times of bereavement.

## Our findings

### Respect, dignity, compassion and empathy

Staff treated people who used the service and those close to them with dignity and respect. Patients spoken with told us they felt supported and well cared for. The practice had an up to date dignity and respect, and chaperone policies in place for staff to refer to for support and advice. Staff had received training in maintaining confidentiality and equality and diversity. Staff were seen to respond to patients compassionately. There was a designated quiet room that staff took patients to if they required a confidential conversation with a member of staff. Staff were familiar with the steps they needed to take to protect patients' dignity. We saw that patient consultations took place in private rooms. Staff described to us the steps they took to protect a patient's dignity during a sensitive examination. Patients confirmed they felt staff effectively protected their privacy and dignity.

Patients received compassionate care. The staff we spoke with all displayed a passion for patient care and were keen for the service to be patient centred. We saw that staff were kind and caring both on the telephone and face to face. We observed a distressed patient attending the surgery for an appointment. Staff responded by taking the patient to a quiet room so they could take time to listen to their concerns and ensure they saw the right clinician. Parents informed us that their children were treated with kindness and staff used age appropriate language to explain things to their children.

One GP we spoke with explained how information about patients who were receiving palliative care, or who had long term conditions, was shared with community nurses during the monthly Gold Standard Framework (GSF) meetings. The GSF is guidance for clinicians to support earlier recognition of patients nearing the end of life. This information had been transferred onto patients' records to ensure they were kept up to date. The practice had a system for a doctor to telephone a patient's relative in the days after the patient died. This enabled the doctor to assess any support the bereaved person may require.

### Involvement in decisions and consent

We looked at patient choice and involvement. Staff explained how patients were informed before their

# Are services caring?

treatment started and how they determined what support was required for patients' individual needs. The clinical staff told us they discussed any proposed changes to a patient's treatment or medication with them. They described treating patients with consideration and respect and said they kept patients fully informed during their consultations and subsequent investigations. Patients we spoke with confirmed this. Patients had the information and support available to them to enable them to make an informed decision about their care and treatment needs.

GPs and nurses demonstrated an understanding of legal requirements when treating children. They understood the Fraser guidelines and Gillick competency. These are used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. We also spoke to parents of young children. They told us staff confirmed their relationship with the child and whether they agreed that their child could be immunised before care was provided.

Staff demonstrated that they were aware of the Mental Capacity Act (MCA) and how it may relate to patients. The Mental Capacity Act (MCA) (2005) is designed to protect people who may require support to make decisions which are in their best interest. Clinicians told us where a patient may not have capacity or required additional support to make a decision, they worked with the community matron, carers and/or family. A representative from a care home told us that not all their residents had capacity to make decisions. However, where necessary are best interest decisions were well documented by the GP and in their records.

# Are services responsive to people's needs?

(for example, to feedback?)

## Summary of findings

The service was responsive to people's needs.

We found that the practice understood the needs of its population and made reasonable adjustments according to the individual needs of patients. There was collaborative working between the practice and other health and social care services which helped to ensure patients received the best outcomes.

The practice acted on patients' suggestions for improving the service. The practice had an active Patient Participation Group (PPG) that was fully involved with decision-making. The PPG is a group of patients registered with the surgery who have no medical training but have an interest in the services provided. The practice participated actively in discussions with the Clinical Commissioning Group about how to improve services for patients in the area. The practice had a clear complaints policy.

## Our findings

### Responding to and meeting people's needs

The practice understood the different needs of the population it served and acted on these to design their services. There were arrangements to ensure that care and treatment was provided to patients with regard to their long term illness or disability. There was a hearing loop system available for patients with a hearing impairment and clear signage informing patients where to go. There was a wheelchair available for patients with mobility problems and a chair lift to the first floor doctors' rooms. There was an accessible parking space. The accessible toilet did not have an alarm system in it so if a patient required assistance they would have to shout. We discussed this with the receptionists. They informed us that they always observed the accessible toilet (it could be viewed from the reception area) and took action if someone was in there a long time.

The practice had a high elderly population. The practice responded to this need by providing care such as the delivery of flu vaccines within the local community. A blood taking service had been established at the practice to increase the accessibility of this service to the elderly and less mobile. Patients with long term chronic conditions, such as diabetes and asthma, received regular checks by appropriately trained nurses and health care assistants. There were clinical leads for each type of long term chronic disease ensuring that GPs maintained a specialist interest in this field of medicine. This meant that patients and staff had pathways to access within the practice to obtain the support they required. There were systems in place to support children, families and patients in vulnerable circumstances. Visiting professionals confirmed that the practice was proactive in responding to their needs.

### Access to the service

The practice opened from 8am to 6.30pm every weekday. For patients unable to attend regular surgery times, a 'commuter clinic' was run every Tuesday and Thursday morning from 6.45am to 8.00am. After 6.30pm and during the weekend, an out of hours service was offered by another provider. Telephone calls were automatically directed to the NHS 111 service. This ensured patients had access to medical advice outside of practice opening hours. Patients we spoke with told us appointment availability

# Are services responsive to people's needs?

## (for example, to feedback?)

was good. They told us they would have to wait a little longer to see a specific GP, but patients understood the reason for this and were happy to choose to do so if they wanted to.

For patients who had an urgent medical condition the practice operated a 'book on the day' appointment system for urgent appointments. If all appointments were taken and the problem could not wait until the next day the patient would be seen as an emergency at the end of the surgery. Home visits were available for patients who were unable to go to the practice.

Patients could order repeat prescriptions through an on-line service, in person or via the pharmacy.

### Concerns and complaints

Only a few of the patients we spoke with were aware of the complaints procedure. The complaints procedure was not on display in either waiting areas, although an information sheet was available on request from reception. The practice web site included details of how patients could take a complaint further if they were not satisfied with the response.

We looked to see whether the practice adhered to its complaints policy and looked at a number of patient complaints in detail. We found that the complaints had been dealt with appropriately and within the timescales set out in the practice's complaints policy. It was also clear that verbal complaints were dealt with in the same way as written complaints. If a patient telephoned the practice to complain, the practice manager would immediately take the call if available.

# Are services well-led?

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

## Summary of findings

The service was well led. There were clear lines of management and the vision and purpose of the service was shared by all staff. Governance structures were robust and there was a system in place for managing risks. There was a Patient Participation Group (PPG) which felt listened to and their views acted upon.

## Our findings

### Leadership and culture

There was a vision to deliver high quality care and promote good health outcomes for patients. This was documented in the practice's statement of purpose which was located on the internal computer system. A summary of this was available in the patient practice leaflet. There was an established management structure which identified key roles and clinical leads. Each member of staff demonstrated an understanding of their area of responsibility and other staff at the practice were able to articulate who key clinical and non-clinical leads were. We saw that there was a good relationship between clinical and non-clinical staff. Staff described the culture within the organisation as supportive and inclusive with a focus on patient care. Staff also told us that the leadership team within the practice was visible and accessible.

### Governance arrangements

The practice had a clear corporate structure designed to provide complete assurance to the management team and local Clinical Commissioning Group (CCG) that the service was operating safely and effectively. Within the governance arrangements there were clearly identified lead roles which included infection prevention and control, complaints, incident management, and safeguarding.

There were processes in place to provide systematic assurance that high quality care was being delivered. The practice worked closely with the CCG by responding to feedback they provided and making local arrangements at practice level to improve care and treatment where needed. For example, CCG feedback identified a high hospital orthopaedic referral rate by the practice. In response to this, we saw evidence that weekly referral meetings were held between the GPs at the practice to ensure the appropriateness of the referrals.

### Systems to monitor and improve quality and improvement

The practice had an effective system to regularly assess and monitor the quality of service that patients received. We saw the practice carried out regular audits. We found the practice had carried out monitoring which included long term medical conditions, minor surgery, incident reporting, and quality and productivity. All audits were

# Are services well-led?

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

evaluated and action plans to improve quality had been put in place when necessary. Some of this monitoring was carried out as part of the Quality and Outcomes Framework (QOF). This is an annual incentive programme designed to monetarily reward doctors for implementing good practice. The practice demonstrated they were meeting the expected targets.

In addition to monitoring and reporting its performance against the national quality requirements, the practice had developed and agreed quality indicators with the local CCG. The indicators were monitored and performance was reported to the CCG on a monthly basis. This enabled the management team and the CCG to see at a glance if any aspect of performance was below expectation and to put plans in place to improve the situation.

The practice had produced a comprehensive register of potential risks to its business. The risks identified were discussed at staff meetings and risk reduction plans were regularly reviewed and updated.

### Patient experience and involvement

Patients who used the service were asked, by the practice, for their views about their care and treatment and they were acted on. This included the use of surveys to gather views of patients. We saw there were systems in place for the practice to analyse the results of the survey for information so that any issues identified were addressed and discussed with all staff members. We saw records of discussions within the minutes of staff meetings. All the patients we spoke with on the day of our inspection told us they received a high quality service from the provider

We found the practice encouraged and valued the involvement of their patients in the Patient Participation Group (PPG) who met quarterly. The PPG is a group of patients registered with the surgery who have no medical training but have an interest in the services provided. The PPG was well established and the membership included a wide age range of people representing carers, mothers and people with long term conditions. The group had clear and published objectives and their meetings were well attended by clinical and non-clinical staff.

The PPG reviewed patient surveys and feedback, all of which was posted on the practice website. The group were also consulted regarding how to improve the quality of services received by patients. The practice manager informed us that it was the PPG that had requested an accessible parking area. This had be marked out in the car park now people with limited mobility had a larger parking space to accommodate wheelchair access.

### Staff engagement and involvement

All staff were fully involved in the running of the practice. We saw there were documented regular staff meetings. This included meetings for clinical staff and meetings that included all staff. This ensured staff were given opportunities to discuss practice issues with each other. There was a clear culture of openness and 'no blame' in place, Staff could raise concerns without fear of reprisals and the provider's whistleblowing procedure supported this.

Staff told us they were actively encouraged to make suggestions and identify ways for the provider's service to improve.

### Learning and improvement

We saw evidence that learning from significant events took place and appropriate changes were implemented. We saw that there were systems in place for the practice to audit and review significant events and that action plans were put in place to help to prevent them occurring again.

As part of the annual review process, staff had clearly defined goals for learning and development. Staff were also encouraged to train for further professional qualifications when appropriate. We saw details contained within staff records. This was in addition to the regular training provided to update learning and skills, along with to implement new developments within primary medical services. This ensured staff had up to date knowledge and skills.

### Identification and management of risk

The practice had an effective system in place to identify, assess and manage risks to the health, safety and welfare of patients who used the service. We saw risk assessments in place for fire hazards. There was a business continuity plan in place which had assessed the risk to patients in the event of such occurrences as an information technology failure, loss of domestic services or a flood. Action plans were in place to manage these risks.

# Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

## Summary of findings

The practice was responsive to the needs of older patients and carers. The practice encouraged older people to attend the practice for a health check and have the flu vaccination. The practice had improved the information it produced for patients about the referral process and told us this had been particularly helpful for some older patients and carers. The practice had established  links with local care homes.

## Our findings

The practice was responsive to the needs of older patients and carers. We were told that the local older population included a relatively high proportion of active patients who were keen to be involved in decisions about their care and understand different treatment options. The practice routinely offered people over 75 a health check in line with national guidance and encouraged older people to have the flu vaccination.

Unplanned hospital admissions and readmissions for older people were reviewed and demonstrable improvements were made.

# People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

## Summary of findings

The practice cared effectively for people with long term conditions. The practice was performing in line with national and local targets for a range of conditions. The provider made clinical staff aware of alerts about relevant guidelines.

The review dates of patients with some long-term conditions such as heart disease, chronic breathing problems and stroke were monitored to ensure their health needs were regularly considered.

## Our findings

The practice had effective systems in place to care for people with long term conditions. The practice was meeting national and local targets for the management of a range of chronic conditions. Clinical staff received alerts about new or updated clinical guidelines on the management of various conditions. The practice operated a review system for patients with complex needs in the local community. These patients were reviewed at monthly meetings with the aim of avoiding unnecessary hospital admissions. The practice followed 'integrated pathways' of care for long term conditions such as asthma and chronic obstructive pulmonary disease (COPD). The practice was meeting national and local targets for the management of a range of chronic conditions.

# Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

## Summary of findings

The practice employed a dual-trained nurse/midwife; they were able to offer midwifery clinics twice a week.

The practice offered a range of services for mothers and babies and was meeting national targets in relation to primary care services for children. Staff understood their responsibilities in relation to safeguarding children and acted when they had concerns.

## Our findings

The practice offered a weekly midwife appointment for expectant mothers. There was a comprehensive range of health care information available in the practice for new and expectant mothers.

The practice was meeting national targets in relation to primary care services for children. The practice provided offered ante-natal care in partnership with the local hospital. A weekly walk-in baby clinic run by the community health visitors was provided.

The practice did not run services specifically aimed at teenagers but the GPs were aware of Gillick competence and the 'Fraser guidelines' and used these to assess younger patients' maturity to make decisions without the consent of their parents when this was appropriate.

All staff were aware of child protection and safeguarding procedures. The practice was able to demonstrate that staff had taken action when they had concerns about potential abuse and child neglect to protect them from harm.

# Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

## Summary of findings

The practice offered extended surgery hours on a Tuesday and Thursday morning each week between 6.45am and 8am. There was no extended hours in the evenings. Patients could also request to have a GP call them back for a telephone consultation to identify if they needed to attend the surgery.

## Our findings

The practice offered extended hours and opened early on two mornings each week to enable patients to access a GP before travelling to work. It was possible to book appointments several weeks in advance. Appointments could be booked by telephone, in person or via the internet.

The adult health-screening programme for people aged between 40 and 75 had been introduced and the practice manager informed us that the patients had responded positively to these health checks.

# People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

## Summary of findings

The practice had identified patients with learning disabilities. There was evidence of effective partnership working with the team for people with learning disabilities that also offered support for carers. The practice told us that their population group did not contain significant groups of people in vulnerable circumstances and so it had not been necessary to make pro-active attempts to reach them.

## Our findings

There was a lead clinician and nurse trained in providing care for patients with learning disabilities. Patients with learning disabilities were invited to attend for chronic disease monitoring and non-attendance was followed up.

Clinicians used learning disability clinical templates to ensure consistency in their assessments and recording. Registers were maintained of patients with learning disabilities and all were invited to attend for annual health checks. Non-attendance was followed up with texts and phone calls, as appropriate.

Patients were able to access the chaperone service and care advisor who may assist them to maintain their independence. Patients spoken with on the day who were identified as being a carer told us the staff were very helpful and supportive and the doctors and nurses were approachable and happy to give help and advice.

# People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

## Summary of findings

The provider worked with community psychiatric nurses and a local psychological therapy service to help ensure that people received the necessary care and support.

## Our findings

The practice had information for patients in the waiting areas to inform them of other services available. For example, for patients who may experience depression or those who would benefit from counselling services for bereavement.

The practice maintained a register of patients who experienced mental health problems. The register was used by clinical staff to offer patients an annual appointment for a health check and medication review.

The practice had information on its website regarding mental health and the services available to support patients.