Avonside Health Centre

Quality Report

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

Summary of findings

Contents

Summary of findings

Overall summary

We found the practice was safe, effective, caring, well-led and responsive to patients' needs. There were systems in place to learn from incidents and respond to safeguarding concerns. The practice was clean. Equipment and medication were fit for purpose and there were appropriate procedures in place to maintain this.

The services provided were designed to promote patients' health and wellbeing. The practice worked collaboratively with other health providers and took action to manage poor staff performance when necessary.

Patients were listened to and involved by respectful staff. There were appropriate procedures in place to include patients in their care.

Appointments were accessible and arrangements were in place to see patients in their own homes when necessary. The service acted upon patients' comments and complaints.

An open culture and management structure meant that staff were engaged, understood their objectives and knew about decisions that affected their work. Risks to patients were managed appropriately.

During our inspection we spoke with people who use the service and read comments they left for us. Patients said they received very good care and were positive about most aspects of the service. However, they felt the provision of a routine blood taking service would improve their experience.

We found that the practice proactively engaged with community teams and targeted vaccination programmes to effectively care for older people.

The flexible approach of the nurse led clinics meant that the service was responsive to the needs of people with long term conditions.

Mothers, babies, children and young people were protected because the service had appropriate systems in place to identify and report child protection concerns.

The availability of appointments at set times outside of normal working hours meant that working age people had their needs considered.

Patients whose circumstances may lead them to have poor access to primary medical services were able to register at the practice through the use of temporary resident registration.

The service had procedures in place to assist in keeping people with mental health issues and limited understanding safe.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found that the service was safe. The structure of management and meetings ensured that staff were informed about risks and decision making. There were incident reporting procedures in place that encouraged learning and action was taken to prevent recurrence of incidents when required. Appropriate systems were in place to identify and respond to concerns about the safeguarding of adults and children. Health and safety risks, cleanliness, equipment and medication were monitored. Staff at the service only completed the tasks they were qualified to do. Patients were protected from the risk of harm and/or unsafe treatment.

Are services effective?

The service was effective. The service reviewed, discussed and acted upon best practice knowledge and information to improve the patient experience. The practice provided a number of services designed to promote patients' health and wellbeing. The nurse led clinics were operated flexibly ensuring that patients could access them in a way that suited their needs and circumstances. There were appropriate systems to ensure staff received the relevant checks, that their skills and abilities were monitored and that poor performance was managed when necessary. The service took a collaborative approach to working with other health providers, including performing case by case reviews for palliative patients. Patients received a coordinated and targeted approach to care, provided by competent staff in an effective and timely manner.

Are services caring?

The service was caring. On the day of our inspection, we saw staff interacting with patients in a respectful and caring manner. There were a number of arrangements in place to promote patients' involvement in their care. There were also arrangements to identify and assess patients who may have difficulty in understanding their care. Patients told us they felt listened to and included in decisions about their care.

Are services responsive to people's needs?

The service was responsive. Services were targeted at those most at risk such as older people and those with long term conditions. Appointments, including those required out of normal working hours or in an emergency were readily available. Patients were visited in their own homes where appropriate. A number of suitable

Summary of findings

methods were available for patients to leave feedback about their experiences. The service demonstrated it responded to people's comments and complaints and where possible, took action to improve the patient experience.

Are services well-led?

The service was well-led. Most staff were aware of individual accountabilities and responsibilities and understood their own roles and objectives. Staff felt engaged in a culture of openness. An appropriate management and meeting structure ensured that staff were aware of how decisions were reached and of their roles in implementing them. The management structure ensured that risks to patient care were anticipated, monitored, reviewed and acted upon. The service listened to representatives of the patient population. At our inspection, we saw that good patient care was facilitated by an open, accountable culture where staff and people were engaged and decision making processes were clear.

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 service responded to the care needs of older people. Older people had access to a named GP and received targeted vaccinations. The service proactively engaged with community teams and local care homes to ensure that older people received effective care when they were not able to visit the practice

People with long-term conditions
The service encouraged feedback and participation from people with long term conditions through the virtual patient reference group (an online community of patients who work with the practice to discuss and develop the services provided). There was a well-led approach to anticipating risks to patient care affecting those with long term conditions. GPs attended referral meetings to ensure patients received effective care. Patients had access to flexible nurse led clinics where they were able to attend any clinic for any condition

Mothers, babies, children and young people
The flexible approach to nurse led clinics offered mothers the opportunity to attend the same clinics as their children. The service kept children safe through the use of established procedures for alerts about childhood immunisations and the identification and reporting of child protection issues

The working-age population and those recently retired
The service encouraged feedback and participation from people of working age through the virtual patient reference group (an online community of patients who work with the practice to discuss and develop the services provided). Extended opening hours on a Monday evening until 8.30pm and alternate Saturday mornings for three hours, meant that the service responded to the needs of working age people

People in vulnerable circumstances who may have poor access to primary care
Patients whose circumstances may lead them to have poor access to primary medical services were able to register at the practice through the use of temporary resident registration.

Summary of findings

People experiencing poor mental health

The service had procedures in place to identify and assess people experiencing poor mental health or those who may lack understanding of their care. We saw examples of where these procedures had been used appropriately to keep people with mental health issues safe and cared for

Summary of findings

What people who use the service say

During our inspection, we spoke with nine people who use the service, reviewed comment cards left by them and spoke with representatives of the patient participation group (the PPG is a group of patients who work with the practice to discuss and develop the services provided). People told us the service, including their patient experience, had improved in the past year. They felt the staff were efficient and friendly and said they were listened to by the GPs, with whom they had good relationships.

Patients said their needs were met by the provision of very good care. Patients made positive comments about the appointments system, referrals to other health care providers, the repeat prescription service and home visits by the GPs. The results of the service's 2014 patient survey showed that 97% of the 345 respondents were satisfied with their care. Most patients identified the provision of a routine blood test service at the practice as the only thing that could improve their experience further.

Areas for improvement

Action the service COULD take to improve

Ensure all staff review safety alerts appropriately.

Good practice

Our inspection team highlighted the following areas of good practice:

By offering flexible nurse led clinics, the service enabled mothers to attend the same sessions as their children when being seen for different purposes.

Avonside Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a second CQC inspector, a GP acting as a specialist adviser and an expert by experience (a member of the team with carer responsibilities and considerable experience using the health care system).

Background to Avonside Health Centre

Avonside Health Centre provides a range of primary medical services from a single modern, purpose built facility in Portobello Way, Warwick, CV34 5GJ. It serves a patient population of 8719 from the surrounding urban areas of Warwick and Leamington Spa. The area served has a slightly higher rate of deprivation than South Warwickshire in general (which has lower than national average rates). The local population is predominantly white British. However, 5.1% of the population is Asian and there is a notable agricultural migrant worker population, mainly from Poland and Portugal. The local population has a higher than average number of older people. The full clinical staff team includes five GP partners, one locum GP, two trainee GPs, three nurses, a nurse practitioner and a healthcare assistant (HCA). The team is supported by a practice manager, reception and administration teams.

Why we carried out this inspection

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

How we carried out this inspection

Before our inspection visit, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. We carried out an announced inspection visit on 20 May 2014. During our inspection we spoke with a range of staff including the GP partners, the locum GP, nurses, the HCA and the practice manager. We spoke with people who use the service and their representatives on the patient participation group (the PPG is a group of patients who work with the practice to discuss and develop the services provided). We observed how patients interacted with staff and talked with some carers and family members. We reviewed national patient surveys, the practice's own patient survey and CQC comment cards used by patients to share their views and experiences of the service with us.

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?

Detailed findings

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem

Are services safe?

Summary of findings

We found that the service was safe. The structure of management and meetings ensured that staff were informed about risks and decision making. There were incident reporting procedures in place that encouraged learning and action was taken to prevent recurrence of incidents when required. Appropriate systems were in place to identify and respond to concerns about the safeguarding of adults and children. Health and safety risks, cleanliness, equipment and medication were monitored. Staff at the service only completed the tasks they were qualified to do. Patients were protected from the risk of harm and/or unsafe treatment.

Our findings

Safe patient care

Before our inspection we looked at background information on Avonside Health Centre and saw the service had a good record on providing safe patient care. We looked at the results of the 2014 patient survey and found that 97% of the 345 respondents were satisfied with their care at the service.

Arrangements were in place to ensure that all staff received an accurate picture of the service's performance and decision making about patient safety. From speaking with staff and our review of documentation, we found that the service had management systems in place, including nominated lead roles for GP partners. Decisions were made through the agreement of all GP partners. The service operated structured meetings to involve all staff so that when decisions were made relating to patient care and safety the information was shared in a timely and accurate manner. The minutes of meetings we looked at demonstrated the overall management and meeting structure was used to report, review and respond to incidents and safeguarding issues.

Learning from incidents

We saw that the service had a significant event reporting policy in place. The staff we spoke with displayed a good understanding of the procedures set out in the policy. We looked at examples of how staff had used the procedure to report untoward incidents and significant events relating to clinical practice and/or staff issues. The minutes of meetings and reports available at the service demonstrated that all incidents and near misses were discussed at GP partner meetings and wider staff meetings. The meetings included discussion on how the incidents could be learned from and any action necessary to reduce the risk of recurrence.

We found that the service had procedures in place to learn from incidents and reduce the risk of harm to patients from any recurrence. We saw that during the investigation of incidents, the relevant patients were involved in the process and informed of any actions taken or outcomes achieved. Every three months the service completed a review of all incidents and events in that quarter to reflect on their learning experiences.

Are services safe?

Safeguarding

We found that there were appropriate systems in place for staff to identify and respond to potential concerns around the safeguarding of adults and children using the service. We saw the service had a safeguarding and child protection policy in place that detailed the responsibilities of staff. One of the GP partners was the nominated lead for safeguarding issues. The staff we spoke with were aware of who was responsible for safeguarding issues. From our conversations with them and our review of training documentation, we saw that all staff (including the GP partners) had received, or were booked to receive safeguarding and child protection training.

The staff we spoke with demonstrated a good awareness of how to identify and report potential safeguarding concerns. They were also aware of the process of alerts used at the service to identify patients under a child protection plan. They told us that safeguarding issues were discussed at staff meetings. Our review of the minutes of the meetings confirmed what staff had told us.

Monitoring safety and responding to risk

We saw that the service had a health and safety policy in place and completed an annual audit of health and safety issues. We looked at documentation which showed there was a schedule of checks in place relating to the lift, fire equipment and procedures and electrical equipment.

From our conversations with staff and our review of documentation we found that they were receiving safety alerts and information on other concerns such as fraud in the local area. We looked at an example of how the service had replaced its defibrillator following a safety concern being received about its previous model. This demonstrated the service was monitoring and responding to potential risks to patient safety. However, we found that each staff member took individual responsibility for receiving the alerts and some colleagues shared them with each other. As there was no lead role for this at the service and no central point for receiving the alerts, there was a risk that not all staff would receive or respond to the alerts appropriately.

Medicines management

The service had robust systems in place to protect people from the risks of unsafe medication and vaccines. During our inspection we saw the service had systems in place to order and check all medications and receive and store vaccinations at the required temperature. The staff we spoke with demonstrated a good understanding of their roles in this and how they responded to any issues or concerns. We looked at documentation which showed that the medications and vaccines at the service were regularly checked. The checks included monitoring the temperature at which the vaccines were stored. We checked the medications and vaccines and found them to be stored securely at the appropriate temperature and within their expiry dates.

Cleanliness and infection control

Systems were in place to maintain the appropriate standards of cleanliness and protect people from the risks of infection. During our inspection we saw that cleaning schedules were in place and weekly spot checks on cleanliness were completed by staff. We saw that all areas of the practice, including the treatment rooms appeared clean. Hand wash facilities, including hand sanitiser were available throughout the premises and the records we looked at showed that staff had received training on hand washing technique. All of the patients we spoke with were positive about the cleanliness of the service. Staff told us they were informed of any issues and requirements through the nominated staff lead for cleanliness and infection control.

We found there were appropriate processes in place for the management of sharps (needles) and clinical waste. We looked at an audit of cleanliness and infection control completed at the service in September 2013. This demonstrated that where issues were identified, appropriate action was taken to rectify them. This had included a professional clean of the carpets and the provision of hand sanitiser gel for the GP bags.

Staffing and recruitment

We found that staff understood what they were qualified to do and this was reflected in how the practice had arranged its services. For example, only the appropriately trained and experienced nurse led on the diabetes clinic. As one nurse was due to leave the practice, another nurse had been recruited to maintain staffing levels. At the time of our inspection, a trainee GP was working at the service and the practice had established a system of supervision for the trainee by a senior partner.

Dealing with Emergencies

We saw that the service had a business continuity plan in place. The plan covered the emergency measures the service would take to respond to any loss of premises,

records and utilities among other things. The relevant staff we spoke with understood their roles in relation to the contingency plan. We looked at the emergency medical equipment and drugs available at the service including oxygen, a defibrillator and adrenaline. All of the equipment and drugs were within their expiry dates. The service had procedures in place to respond to emergencies and reduce the risk to people's safety from such incidents.

Equipment

We looked at documentation which showed the service completed twice yearly checks on its equipment. All of the equipment we saw during our inspection appeared fit for purpose. The relevant staff we spoke with demonstrated a sound awareness of their roles in completing weekly calibration checks on the blood glucose machines to ensure their readings were accurate. We looked at the agenda and minutes of the weekly practice meeting attended by the GP partners and practice manager. These demonstrated that equipment issues were a standing item at the meeting and any such issues were responded to appropriately. Patients were protected from the risk of unsuitable equipment because the service had procedures in place to ensure the equipment was maintained and fit for purpose.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service was effective. The service reviewed, discussed and acted upon best practice knowledge and information to improve the patient experience. The practice provided a number of services designed to promote patients' health and wellbeing. The nurse led clinics were operated flexibly ensuring that patients could access them in a way that suited their needs and circumstances. There were appropriate systems to ensure staff received the relevant checks, that their skills and abilities were monitored and that poor performance was managed when necessary. The service took a collaborative approach to working with other health providers, including performing case by case reviews for palliative patients. Patients received a coordinated and targeted approach to care, provided by competent staff in an effective and timely manner.

Our findings

Promoting best practice

The service reviewed, discussed and acted upon best practice knowledge and information to improve the patient experience. The practice participated in recognised clinical quality and effectiveness schemes such as the national Quality and Outcomes Framework (QOF is a national data management tool generated from patients' records that provides performance information about primary medical services). We looked at documentation which showed that as part of the process, the practice's clinical team met to discuss areas where there was scope for the service to improve. Actions as part of the service design improvements were then agreed and implemented.

Management, monitoring and improving outcomes for people

An information system was in place to ensure the effective and timely delivery of patient care. From our conversations with staff, we found that the nurse led clinics were operated flexibly. Patients could be seen at a clinic time that suited them as opposed to having to attend a set clinic. Also, those patients with more than one long term condition were able to attend for the management and review of each condition at the same time. We saw that a clinical diary system was used to ensure people were invited to attend for an annual review of their long term conditions. The system allowed the nurses to monitor when patients had attended for reviews of such things as their diabetes, asthma or chronic obstructive pulmonary disease (COPD). The system of recall would continue until the person had attended.

Staffing

Systems were in place to ensure that people received care from appropriately qualified staff. All of the staff we spoke with said they could recall completing a series of recruitment checks including criminal records checks, references from previous employers and checks on their professional registration. Most of the staff files we looked at confirmed what staff had told us. However, some paper copies of the checks were missing or not located in the relevant staff files.

We found that the service had systems in place to ensure that its staff remained competent and effective in their roles. From speaking with staff and our review of documentation we found that staff received an appropriate

Are services effective?

(for example, treatment is effective)

induction when joining the service. There was a probationary period in place to ensure that staff were competent to deliver effective care. We saw that all staff at the service were subject to the capability policy which detailed the practice's process for managing poorly performing staff. We looked at an example of how the policy had been used and from this saw that the service was identifying, monitoring and managing poorly performing staff to protect the care and welfare of patients.

There were systems in place to ensure patients received care from competent and effective staff. All of the staff we spoke with said they received an annual appraisal of their performance and competencies. We looked at some examples of these and saw they were also an opportunity for staff to discuss any training requirements. Staff told us that training was very accessible at the service. We saw examples of how staff had participated in training on carers' support and improving the patient experience to assist them in effectively providing a better patient experience.

Working with other services

We found that the service had a collaborative approach to providing care by engaging and communicating with other health providers. For example, the GP partners held monthly meetings with community teams including district and Macmillan nurses to review the care and chronic disease management of palliative patients on a case by case basis. Similar meetings were held monthly for patients with long term conditions. There were also quarterly mental health reviews. Also, the GP partners discussed the transition of care for those patients moving between services (referrals) at their weekly meetings. The people we spoke with who had been referred by the service said the whole experience had been professional and efficient. These meetings and the information sharing between professionals ensured that patients were more likely to experience a coordinated approach to their care.

Health, promotion and prevention

We found the service provided advice to people on issues around their health and targeted some services in order to help people maintain their health. The practice had participated in targeted vaccination programmes for older people and those with long term conditions. These included the shingles vaccine for those aged 70 to 79, and the flu vaccine for people with long term conditions and those over 65. The flu vaccination programme had reached a 78% take up rate.

From our conversations with staff we found that the service offered all new patients a nurse led health check or initial GP consultation on registering. Acceptance of this was voluntary unless the patient was on medication when a GP consultation was required. We saw that from the initial registration data, the service kept a register of those people who identified as carers. From speaking with staff we found that the register was not used to target specific services. There was a risk that carers would not receive targeted and specific health advice and support.

We found that the practice offered a number of services designed to promote people's health and wellbeing and prevent the onset of illness. These included programmes of childhood immunisations and smear testing. We saw that the practice was also preparing to participate in a national initiative of health checks for those aged 40 and over. The service had opted into this and it was not required under its contracts or agreements to provide health services. We saw various health related information leaflets available for patients in the waiting area including those about mental health and diabetes.

Are services caring?

Summary of findings

The service was caring. On the day of our inspection, we saw staff interacting with patients in a respectful and caring manner. There were a number of arrangements in place to promote patients' involvement in their care. There were also arrangements to identify and assess patients who may have difficulty in understanding their care. Patients told us they felt listened to and included in decisions about their care.

Our findings

Respect, dignity, compassion and empathy

We saw that the service had an equality and diversity policy in place. This detailed the behaviours expected of staff. We saw that the policy was reinforced with the provision of equality and diversity training for all staff. During our inspection we found that staff behaviours were in accordance with those expected by the policy. We saw many examples of patients receiving respectful and courteous treatment from the practice reception staff. This was particularly evident when people displayed a limited understanding of what was being said. We saw the GP partners interacting with patients in the waiting area in a friendly and caring manner. Findings from the practice's 2014 patient survey showed that 92% of the 345 respondents always felt treated with dignity and respect. We found that most staff recognised that individual GPs would contact bereaved partners of deceased patients. Empathy and respect for patients who use the service was considered as part of their care.

Involvement in decisions and consent

All of the nine patients we spoke with said they felt listened to and had a communicative relationship with the GPs. We also read comments left for us by people using the service stating they felt involved in, and received explanations about their care. We saw the practice had a number of facilities available to promote people's understanding of and involvement in their care. These included a mobile hearing loop at reception that could be used anywhere in the practice. There was also a booking in system available in English, Polish, Punjabi and Portuguese. The staff we spoke with demonstrated an awareness that these languages had been chosen to represent the largest ethnic groups in the practice population. We were told that a full translation service was also available by telephone or in person, but that there was little demand for this.

The staff we spoke with were clear on the processes used at the service for dementia and cognitive screening. We found that in all cases, the GP partners were the point of contact for staff in assessing people who may display signs of limited understanding. All the staff we spoke with were able to give appropriate examples of when they had taken further advice from one of the GPs on concerns relating to a

Are services caring?

patient's mental health and/or their ability to understand information. The service had made suitable arrangements to ensure that people were involved in, and able to participate in decisions about their care.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive. Services were targeted at those most at risk such as older people and those with long term conditions. Appointments, including those required out of normal working hours or in an emergency were readily available. Patients were visited in their own homes where appropriate. A number of suitable methods were available for patients to leave feedback about their experiences. The service demonstrated it responded to people's comments and complaints and where possible, took action to improve the patient experience.

Our findings

Responding to and meeting people's needs

We found the service had a number of measures in place to respond to patients' differing needs. From its review of patient and local statistical information, the practice was aware of its higher than average population of older people. In response, all patients over the age of 75 had a named GP. We saw that the GPs also engaged with community teams including district nurses and Macmillan nurses to ensure each person received a case by case review during palliative care.

From our conversations with staff, we found the service responded with a reactive approach to vulnerable groups such as the homeless, migrant workers and gypsy/traveller communities. All the staff we spoke with were clear that all people requiring an appointment would be seen. A policy of registering transient or difficult to reach people as temporary residents had been implemented to ensure all people had access to the practice services. By targeting and/or accommodating various population groups, the service attempted to meet the needs of those people.

The service was proactive in ensuring patients requiring a referral received appropriate care as they transferred between services. All the GPs discussed referrals at their weekly meetings on an individual basis to assess appropriateness. Those patients we spoke with who had required a referral said the process was professional and efficient.

Access to the service

The service was accessible to people because it responded to the varying requirements and preferences of its patient population. On the day of our inspection we checked the appointment system and found the longest a person would need to wait to see the doctor of their choice was four days. If the choice of doctor was not important, then appointments were available before that, including on the same day. The practice operated an emergency surgery every evening, bookable from the morning and throughout the day. All the staff we spoke with were clear that the emergency surgery would continue until all people requiring such an appointment were seen. We saw that the appointment system allowed for this.

As well as being open all day Monday to Friday, the practice opened for a bookable appointment service on Monday

Are services responsive to people's needs?

(for example, to feedback?)

evenings until 8.30pm and alternate Saturday mornings for three hours. This allowed access to services for those who found attending in working hours difficult. Results from the last patient survey completed by the service and its patient participation group (the PPG is a group of patients who work with the practice to discuss and develop the services provided), demonstrated that 98% of the 345 patients who responded were satisfied with the extended hours.

From our conversations with staff, we found that the GPs organised and managed their own caseloads of visits to patients in their own homes. Most of the GPs available were providing home visits on the day of our inspection. We found that all the patients requiring a home visit on that day received one. All of the patients we spoke with who had required a home visit at some point said the service was easy to arrange and reliable.

We observed that a dedicated clerk was available every afternoon to ensure that repeat prescriptions were processed on the day. Patients were able to drop their requests at the surgery or use an online request service. Repeat prescriptions were then available to collect from the practice or a nominated pharmacy. Those patients we spoke with who had used the repeat prescription service said it was easy to use and efficient.

We saw that the practice's website detailed how the appointments system and repeat prescriptions service operated. Instructions on how to register for the online repeat prescriptions service and how patients could make appointments, including seeing a GP urgently were accessible. The practice leaflet and an information notice board available in the waiting area also introduced the basics of how patients could access the service and the appointments system.

Concerns and complaints

We saw that the service had a complaints procedure in place. This detailed the full complaints process including timescales and staff responsibilities. All of the patients we spoke with understood how to complain and details on the process, including advocacy leaflets were available in the reception area. Also available was a comments box with forms available for patients to complete.

We looked at how the service responded to the comments and few complaints it received. We saw that all comments received were responded to, including those complimenting the service. Where required, a full explanation was provided by the practice on the subjects raised. We saw that many of the comments related to the practice not offering a routine blood test service. Patients were instead required to attend the local hospital for this service. Each of the comments had been responded to detailing the reasons why the practice did not offer the service, who had reached the decision and how the decision would be reviewed in the future.

We looked at a written complaint received by the practice and saw that the complainant was contacted to discuss the issues raised. As a result, the practice had agreed actions to resolve the complaint to the patient's satisfaction. We saw that the actions were taken and the complainant formally responded to in writing in accordance with the service's own procedure. A system was in place to receive and respond to complaints and comments made by people who use the service. Also, the service took steps to resolve complaints to the satisfaction of patients.

The practice's patient participation group (the PPG is a group of patients who work with the practice to discuss and develop the services provided) engaged with patients to feedback on areas of concern or interest to them and the service took action in response to this. We spoke with representatives and looked at meeting minutes of the service's PPG. From this, we found the group was using an online survey software (Survey Monkey) to target specific areas of concern for feedback from the online virtual patient reference group (the vPRG is an online community of patients who work with the practice to discuss and develop the services provided). The PPG had also developed questions for the annual survey distributed to patients in February 2014. This had enabled the group to focus the questions on targeted areas of interest. From this, the PPG had detected that 5% of the 345 patient respondents felt a routine blood testing service at the practice would improve their experience. As a result, the practice and PPG had agreed an action to discuss models of how this may work and assess if delivery was possible when the next contract was available in March 2015.

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. Most staff were aware of individual accountabilities and responsibilities and understood their own roles and objectives. Staff felt engaged in a culture of openness. An appropriate management and meeting structure ensured that staff were aware of how decisions were reached and of their roles in implementing them. The management structure ensured that risks to patient care were anticipated, monitored, reviewed and acted upon. The service listened to representatives of the patient population. At our inspection, we saw that good patient care was facilitated by an open, accountable culture where staff and people were engaged and decision making processes were clear.

Our findings

Leadership and culture

Whilst there was no formalised approach to leadership, strategy and values, the practice was seen by all who worked for it as well-led with a culture that facilitated an improved patient experience. From our conversations with staff and our review of documentation, we found that the service had no formalised or written strategy or values statement. However, all the staff we spoke with agreed that excellent patient care and service was the overarching objective of their work.

All of the staff we spoke with were clear on their roles and personal objectives. Staff at all levels said they felt the practice was well-led by a visible and proactive management team. They told us that communication at the service was good and there was a culture of openness that allowed staff to constructively challenge practices in order to improve the patient experience. The minutes of both clinical and staff meetings we looked at confirmed what staff had told us. They showed that all types of work practice, staff and clinical issues and any relevant decisions relating to them were communicated and discussed throughout the staff team.

Governance arrangements

The service had decision making processes in place. From our conversations with staff and our review of documentation, we found that the service mostly had clear lines of accountability and responsibility. We saw there were nominated leads for such areas as safeguarding, infection control and liaison with the clinical commissioning group (CCG). The staff we spoke with agreed that management decisions were reached by GP partner consensus. We saw that regular management and clinical meetings involving the GP partners were held to facilitate this process. We found that the practice participated in quality and productivity audits for its local CCG. For example, the practice had researched and provided an annual statistical return to the CCG on the amount of patient visits to accident and emergency departments (A & E) that may have been avoidable. Through this work, the service had concluded that most of its patient visits to A & E had been outside of practice hours

Are services well-led?

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

and were necessary and therefore no changes were required to the way the practice operated. A similar conclusion was reached following an audit on medications that may cause harm through falls.

Systems to monitor and improve quality and improvement

We found that despite not having a formalised corporate risk register, the service had systems in place to monitor and improve quality. We found the service reviewed all the comments and complaints it received and, where necessary, took the appropriate action to improve the patient experience. Also, the service had an appropriate system in place to report and review all clinical and non-clinical incidents and take action to prevent recurrence.

Patient experience and involvement

We found that the practice had systems in place to listen to the views of people who use the service. This was because the practice had both a patient participation group (the PPG is a group of patients who work with the practice to discuss and develop the services provided) and an online virtual patient reference group (the vPRG is an online community of patients who work with the practice to discuss and develop the services provided). Between them, the groups were mostly representative of the patient community. We saw that through meetings or emails the groups were able to feedback their views on a range of practice issues. The members of the PPG we spoke with felt the group was valuable and had achieved some success. We saw that input from the group had led to the service changing its repeat prescription process and this received positive feedback from the people we spoke with. However, substantial improvements to the patient experience achieved through the group were limited.

We saw that the PPG was involved in designing questions for the 2014 patient survey. Patients were proactively involved in targeting and encouraging the feedback of other patients. The survey was distributed to patients in February 2014 and responses were received from 345 people. The results showed that 91% of patients who had used the repeat prescription service and who responded to the survey were satisfied. We saw that the survey also gave people the opportunity to comment on the service in general. The work of the PPG was described in an annual report. This accompanied the published results of the patient survey with an action plan on how the practice and the PPG would work towards achieving improvements recommended by patients, including nurse appointments being bookable online.

Staff engagement and involvement

From our conversations with staff and our review of documentation, we found that all staff were engaged and involved in the service. We saw this was achieved mainly through the use of staff, management and clinical meetings, but also through the use of written team updates. We looked at examples of the minutes of staff meetings and the monthly team update and saw they included examples of discussion, involvement and information on a range of practice related subjects. These included, but were not limited to, recruitment, practice systems and processes and patient feedback. All of the staff we spoke with said that through attending the meetings and working in the open culture at the service, they felt they had a say in the running of the practice.

Learning and improvement

The service was proactive in reviewing, managing and learning from incidents and best practice knowledge to improve the patient experience. The minutes of meetings we looked at showed that all staff discussed how the service could learn from and reduce the risk of recurrence of incidents and near misses. Every three months, the service completed a review of all incidents and events in that quarter to reflect on their learning experiences.

We looked at documentation which showed that as part of the Quality and Outcomes Framework (QOF is a national data management tool generated from patients' records that provides performance information about primary medical services), the practice's clinical team met to discuss areas where there was scope for the service to improve. Actions as part of the service design improvements were then agreed and implemented.

Identification and management of risk

We saw that the service had an established process for management, communication and decision making. The GP partners met regularly with the practice manager in a practice meeting and with the nurses in a clinical meeting. Identifying and managing risk through such things as incident reporting and staff planning were standing items

Are services well-led?

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

on the agendas of those meetings. There were processes in place, such as wider staff meetings and briefings, to ensure all staff were aware of the discussion and decision making from those meetings.

The service identified and managed the risk of staff absence and its impact on patient care. At the time of our inspection, the service was going through a period of a number of staff changes. This included the departure of an experienced nurse, the planned absence of a GP partner and the upcoming retirement of another GP partner. From our conversations with staff and our review of documentation, we saw that the service had begun to discuss and plan for the staff departures through its management meetings and processes. This had resulted in a locum GP working at the service during our inspection and the arrival of a newly employed nurse the day before.

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 service responded to the care needs of older people. Older people had access to a named GP and received targeted vaccinations. The service proactively engaged with community teams and local care homes to ensure that older people received effective care when they were not able to visit the practice.

Our findings

We found that the service provided a named GP for patients aged 75 and over. This system allowed each GP to provide more consistent care to patients in that age group. We saw that the service had provided two targeted vaccinations to older people. The shingles vaccine was available to those aged 70 to 79 and the flu vaccine to those aged 65 and over. The take up rate for the flu vaccine was 78%. This demonstrated that the service was responsive to the needs of older people. We found that GP partners at the service worked in partnership with community teams such as district and Macmillan nurses to provide effective palliative care to patients. We found that the service responded to the needs of older people who could not attend the surgery. The GP partners completed home visits, including those to local care homes so that older people had access to the same care as those able to attend the practice.

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 service encouraged feedback and participation from people with long term conditions through the virtual patient reference group (an online community of patients who work with the practice to discuss and develop the services provided). There was a well-led approach to anticipating risks to patient care affecting those with long term conditions. GPs attended referral meetings to ensure patients received effective care. Patients had access to flexible nurse led clinics where they were able to attend any clinic for any condition.

Our findings

We found that people with long term conditions were encouraged to feedback their care experience and participate in the debate about how the practice operated and the services it provided. This was because the practice operated a virtual patient reference group (the vPRG is an online community of patients who work with the practice to discuss and develop the services provided) for those who found attending patient participation group (PPG) meetings at the practice difficult. We saw that 49% of the membership of the vPRG identified as living with a long term condition or chronic illness.

We saw examples of how the service had anticipated future risks to some people with long term conditions. The nurse with a background and training in diabetes was leaving the service. To prevent this impacting on diabetic patients, the practice had recalled all relevant people for their annual review before the nurse's departure. A new nurse had also been recruited. The service had also responded to the care needs of this group with a targeted flu vaccination programme.

We saw that the practice operated with a flexible approach to their nurse led clinics. This enabled people with long term conditions to access clinic services when it suited them as opposed to fitting in with a particular clinic on a set day. Those with more than one long term condition were able to have all their reviews together in the same clinic. The service was proactive in ensuring patients requiring a referral received appropriate care as they transferred between services. All the GPs discussed referrals at their weekly meetings on an individual basis to assess appropriateness. Those patients we spoke with who had required a referral said the process was professional and efficient.

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 flexible approach to nurse led clinics offered mothers the opportunity to attend the same clinics as their children. The service kept children safe through the use of established procedures for alerts about childhood immunisations and the identification and reporting of child protection issues.

Our findings

We saw that the service responded to the needs of mothers and children by offering flexible programmes of smear testing and childhood vaccinations. When required, a mother could attend the same clinic session with her children for different purposes. We saw that in the interests of child safety, the service had established a system of alerts for those who had not received their scheduled immunisations. This alert was repeated on both the child's and mother's patient records and would continue until the immunisation was provided.

The service had appropriate systems in place to identify and protect children at risk of abuse. We found that one of the GP partners was the identified lead for safeguarding and child protection issues. We saw that all staff had received or were booked to receive child protection training and in our conversations with them, they displayed a good understanding of how to identify and report concerns.

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 service encouraged feedback and participation from people of working age through the virtual patient reference group (an online community of patients who work with the practice to discuss and develop the services provided). Extended opening hours on a Monday evening until 8.30pm and alternate Saturday mornings for three hours, meant that the service responded to the needs of working age people.

Our findings

We found that the service responded to the needs of working age people. The practice had designed access to appointments to meet the needs of those who found it difficult to attend during the working day. We saw that bookable appointments were available on Monday evenings until 8.30pm and alternate Saturday mornings for three hours.

We found that working age people were encouraged to feedback about their care and participate in the debate about how the practice operated and the services it provided. The practice operated a virtual patient reference group (the vPRG is an online community of patients who work with the practice to discuss and develop the services provided) for those who found attending patient participation group (PPG) meetings at the practice difficult. We saw that 64% of the membership of the vPRG identified as being aged 25 to 54 years old.

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

Patients whose circumstances may lead them to have poor access to primary medical services were able to register at the practice through the use of temporary resident registration.

Our findings

We found that the service had a reactive approach to providing services to many people in vulnerable circumstances. Homeless people, migrant workers, people from the gypsy/traveller communities and others who may find accessing GP services difficult were not prevented from accessing services at Avonside Health Centre. This was because the service operated a system of registering all people who required access to their services as temporary residents. This meant that all people, regardless of their circumstances, would be seen at the practice.

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 service had procedures in place to identify and assess people experiencing poor mental health or those who may lack understanding of their care. We saw examples of where these procedures had been used appropriately to keep people with mental health issues safe and cared for.

Our findings

There were procedures in place to ensure that people experiencing poor mental health received the appropriate care. During our conversations with them, staff at the service demonstrated a good understanding of the process used at the service to identify patients who may lack understanding of their care or the ability to make decisions relating to their care. Staff were aware that the GP partners were responsible for completing the relevant assessments where required. The staff we spoke with were able to give appropriate examples of when they had taken action to refer people to the GPs due to concerns about their mental health. The GP partners we spoke with said the local mental health crisis team was very accessible to them and the duty doctor had responsibility for liaising with them as and when required.