Parkgate Medical Practice

Quality Report

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Date of inspection visit: 4 March 2015
Date of publication: 25/06/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out this comprehensive inspection on 4 March 2015.

Overall, we rated this practice as good.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed.
- The practice provided a good standard of care, led by current best practice guidelines.
- Patients were treated with dignity and respect.
- The buildings were clean, and the risk of infection was kept to a minimum.
- The practice provided effective care and support to people in vulnerable circumstances, such as homeless people and those from travelling communities.

However, there were also areas of practice where the provider needs to make improvements.

While patients could access appointments, feedback from the patients showed that they were dissatisfied with the appointments system and the difficulties in obtaining appointments. Also not all clinical staff had received training on the Mental Capacity Act.

The provider should:

- Continue to explore solutions to improve patient satisfaction in the accessibility of appointments.
- Provide all necessary staff with training on the Mental Capacity Act.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood their roles and responsibilities in raising concerns and reporting incidents. Lessons were learned from incidents and these were communicated throughout the practice. The practice had assessed risks to those using or working at the practice and kept these under review. There were emergency procedures in place to keep people safe. There were sufficient numbers of staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Guidance from the National Institute for Health and Care Excellence (NICE) was referred to routinely, and people's needs were assessed and care planned in line with current legislation. This included promotion of good health and assessment of capacity where appropriate. Staff had received training appropriate to their roles, although not all clinical staff had received Mental Capacity Act training. Clinical staff undertook audits of care and reflected on patient outcomes. The practice worked with other services to improve patient outcomes and shared information appropriately.

Are services caring?

Good

The practice is rated as good for providing caring services. The feedback gathered through the inspection process was positive, with patients stating they were treated with compassion, dignity and respect, and were involved in their treatment and care. Staff respected patient confidentiality. The practice provided support to bereaved families.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had extended opening hours and access to an overflow clinic for patients who were carers or who worked. However, feedback from patients highlighted that they had concerns about being able to obtain an urgent appointment. The practice was aware of this issue and were in the process of recruiting more clinical staff. The practice had a good overview of the needs of their local population and proved additional care and support to vulnerable groups. The practice had good facilities and was well equipped to meet patient need. Information was provided to help people make a complaint and there was evidence of shared learning with staff.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. There was a visible management team, with a clear leadership structure. Staff felt supported by management. The practice had a vision and values which staff were clear about. There were systems in place to monitor quality and identify risk. The practice had an active Patient Participation Group (PPG) and was able to evidence where changes had been made as a result of PPG and staff feedback.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice held multi-disciplinary meetings to ensure the needs of those with chronic conditions or end of life care were met. Care plans were tailored to meet to individual needs and circumstances. Patients and their carer's were involved in this process. The practice also undertook opportunistic screening for the early signs of dementia and offered health checks to carers. The over 75's had a named GP. Information was shared with other services, such as out of hours services. Nationally reported data showed the practice had good outcomes for conditions commonly found in older people.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. People with long term conditions were monitored and discussed at multi-disciplinary clinical meetings so the practice was able to respond to their changing needs. Clinical staff had obtained qualifications in specific disease areas and the clinical team met regularly to discuss NICE guidelines and clinical cases. This ensured that patients received the most appropriate treatment. Information was made available to out of hours providers for those on end of life care to ensure appropriate care and support was offered. People with conditions such as diabetes and asthma attended regular nurse clinics to ensure their conditions were appropriately monitored and were involved in making decisions about their care. The practice routinely followed up non-attenders to ensure they had the required routine health checks.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place to identify children who may be at risk, those on a child protection plan or looked after children. The practice monitored levels of children's vaccinations and immunisation rates were mostly above the national average for childhood immunisations. The practice had recognised the difficulties young people can experience in accessing health services and worked with a group of young patients to make services more friendly and accessible and had gained the 'Investing in Children's' award. There were protected daily appointment slots to ensure that children who were ill could be seen in a timely manner.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working population had been identified and services met these needs. Routine appointments could be booked in advance, or made online. Repeat prescriptions could be ordered online. Longer appointments and extended hours opening were available. Working people had access to additional GP appointments, provided in the Darlington area, on Saturday and Sunday.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice had a register of those who may be vulnerable, including those who were homeless. They were offered annual health checks and opportunistic screening when they visited the practice. Patients or their carers were able to request longer appointments if needed. The practice had a register for looked after or otherwise vulnerable children and worked with school nurses to follow up if any routine appointments were missed. The practice supported patients engaged with substances reduction services by ensuring the monitoring tests were taken and reported to the initiating service. Potential misuse of drugs was minimised by dose reduction and monitoring within the practice.

The computerised patient plans were used to flag up issues where a patient may be vulnerable or require extra support, for instance if they were a carer. Staff were aware of their responsibilities in reporting and documenting safeguarding concerns.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Nationally returned data showed the practice performed well in carrying out additional health checks and monitoring for those experiencing a mental health problem. For instance, 95% of patients diagnosed with dementia had their care reviewed in last 12 months, which was above the national average. The practice identified and referred patients in need of mental health support to the Primary Care Mental Health service. It also supported patients undergoing a mental health crisis with onward referral to the crisis team. The practice also supported patients with severe mental health issues who lived at a nearby residential home, by offering reviews of their physical health. These reviews were also offered to all patients on the practices mental health register.

Summary of findings

What people who use the service say

In the NHS England GP Patient Survey from July 2013 - March 2014 84% of patients reported their overall experience as good or very good; this was in line with the national average. The survey also showed higher than average levels of satisfaction for nurses treating patients with care and respect and involving them in decisions, 94% and 92% respectively. 85% of patients also said it was generally easy to get through to the GP surgery on the phone.

The practice had also undertaken a survey of patients between July and August 2014 and 84% of the patients who responded rated their overall experience at the surgery as good, very good or excellent.

We spoke to two members of the Patient Participation Group (PPG) and five patients during the inspection. We also collected 40 CQC comment cards which were sent to the practice before the inspection for patients to complete.

The majority of feedback collected on the day indicated patients were satisfied with the service provided, that they were treated with dignity and respect and that staff were caring, professional and approachable. The most frequent complaint was difficulty in getting appointments.

Areas for improvement

Action the service SHOULD take to improve

- The provider should continue to explore solutions to improve patient satisfaction in the accessibility of appointments.
- Provide all necessary staff with training in the Mental Capacity Act.

Parkgate Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a specialist advisor GP and Practice Manager.

Background to Parkgate Medical Practice

Parkgate Medical Practice provides Primary Medical Services to a population of 4,741 patients based at Park Place in central Darlington. The practice is part of the Intrahealth Limited group. The practice operates from a purpose built healthcare facility which is shared with other community based health services.

There are three female salaried GPs, a nurse practitioner and a healthcare assistant. They are supported by a team of management, reception and administrative staff. Out of Hours services are provided via the NHS 111 service.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures; family planning; maternity and midwifery services; surgical procedures, and treatment of disease, disorder and injury. The practice population aged over 65 years is lower than the England average. The practice is in a comparatively deprived area and has higher than average numbers both of older people and children in income deprived households compared to the national average.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. The provider was selected at random from the CCG area.

We carried out the inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

Detailed findings

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 4 March 2015. During our visit we spoke with a range of staff including the practice manager, GP's, nursing staff, healthcare assistant and administrative and reception staff. We also spoke with two members of the Patient Participation Group and patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service. We reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included reported incidents, national patient safety alerts and complaints, some of which were then investigated as significant events. Prior to inspection the practice gave us details of complaints and significant events from within the last 12 months.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The records showed that staff reported incidents, including their own errors. Significant events within the practice were also reported monthly to Intrahealth's clinical governing body.

The practice had systems in place to record and circulate safety and medication alerts received into the practice. We found that GPs and nurses were aware of the latest best practice guidelines and incorporated this into their day-to-day practice.

We reviewed safety records and incident reports and minutes of meetings where these were discussed. These showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were an agenda item on the clinical meeting which was attended by both clinical and administrative staff. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue of concern and felt encouraged to do so.

We saw details of how incidents were managed and monitored over the past year. Incidents and significant events had been raised by both administrative and clinical staff. We tracked these incidents and saw from the records all were completed in a comprehensive and timely manner. We saw that incidents were reviewed; learning identified and changes to practice established. An example of this was reminders issued to staff about how patients could access overflow clinics to minimise delays in patient care. It was clear from the documentation that patients were informed when something that had gone wrong, the actions taken and apology given.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Staff had received relevant role specific training on safeguarding and staff we spoke to could describe how they would identify signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. However, the safeguarding vulnerable adults' policy had not been reviewed since April 2013.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children and they had had the appropriate training to enable them to fulfil this role. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. Safeguarding concerns were discussed at clinical meetings.

There was a system to highlight vulnerable patients on the practice's electronic records. This included children on a child protection plan, looked after children, adults with safeguarding concerns, patients from travelling communities or with substance misuse issues. The clinical staff confirmed they were able to identify and follow up children, young people and families. There were systems in place for identifying children and young people with a high number of A&E attendances. Child protection case conferences and reviews were attended by staff where appropriate. We were told that children who persistently fail to attend appointments for childhood immunisations were followed up with letters and discussed with the health visitor or school nurse.

Good

Are services safe?

There was a chaperone poster in the waiting room and in all consulting rooms. Chaperoning was undertaken by the nursing staff and they understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures. The practice staff followed the policy.

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

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that clinical staff had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. There was a process to regularly review patients' repeat prescriptions to ensure they were still appropriate and necessary. Any changes in medication guidance were communicated to clinical staff. This ensured that staff were aware of any changes and patients received the best treatment for their condition.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

GPs reviewed their prescribing practices at least annually, or as and when medication alerts were received. In addition the Intrahealth pharmacist undertook regular reviews of the GPs prescribing practice to ensure that it was in line with current guidance and best practice. These reviews were reported back to the GPs.

Cleanliness and infection control

We observed all areas of the practice to be clean, tidy and well maintained. Patients we spoke with told us they found the practice to be clean and had no concerns about cleanliness. The practice had up to date infection prevention and control (IPC) and waste disposal policies. There was an identified IPC lead.

We saw evidence that staff had training in IPC to ensure they were up to date in all relevant areas. Aprons, gloves and other personal protective equipment (PPE) were available in all treatment areas as was hand cleaning liquid and safe hand washing guidance. Sharps bins were appropriately located, labelled, closed and stored after use. We saw that cleaning schedules for all areas of the practice were in place. Cleaning was carried out by an external company. Public toilets were observed to be clean and have supplies of hot water, soap, and paper towels.

Staff said they were given sufficient PPE to allow then to do their jobs safely, and were able to discuss their responsibilities for cleaning and reporting any issues. Staff we spoke with told us that all equipment used for invasive procedures was disposable. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We saw that other equipment such as blood pressure monitors used in the practice were clean.

The practice had had an infection control audit undertaken in February 2015 by the infection control nurse from the nearby hospital. No significant issues were identified. Due to a change in staff the practice had recently transferred IPC responsibilities to the practice nurse. We were told that they would be undertaking regular IPC audits in the future.

The practice had annual testing for legionella (a germ found in the environment which can contaminate water systems in buildings). This was undertaken by an external professional company.

Equipment

We found that equipment such as weighing scales, spirometer, ECG machines (used to detect heart rhythms) and medicine fridges were on external contracts to be checked and calibrated on a timely, regular basis to ensure they were functioning correctly. Regular external checks were carried out on equipment such as fire extinguishers and fire alarms and portable appliance testing had been carried out.

Good

Are services safe?

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Staff told us they were trained and knowledgeable in the use of equipment for their daily jobs, and knew how to report faults with equipment.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice also had access to locum doctors to cover additional sessions. These were provided through a corporate contract held by Intrahealth. At the time of our inspection the practice was in the process of recruiting two advance nurse practitioners to work closely with GPs. Staff told us there were enough staff to keep patients safe although resources were currently stretched. It was thought that the situation would improve when the advance nurse practitioners came into post. The first was due to be in post at the end of March.

Monitoring safety and responding to risk

We found that staff recognised changing risks within the service, either for patients using the service or for staff, and were able to respond appropriately. There were procedures in place to assess, manage and monitor risks to patient and staff safety. These included regular checks and risk assessments of the building, the environment and equipment and medicines management, so patients using the service were not exposed to undue risk.

There were health and safety policies in place covering subjects such as fire safety, manual handling and equipment and risk assessments for the running of the practice. These were all kept under review to monitor changing risk.

Patients with a change in their condition or new diagnoses were reviewed appropriately, which allowed clinicians to monitor treatment and adjust according to risk. Information on patients was made available to out of hours' providers as required so they would be aware of changing risk. All patients who had been discharged from hospital were contacted within three days to review their care needs.

Arrangements to deal with emergencies and major incidents

Staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. We saw records confirming staff had received Cardio Pulmonary Resuscitation training. Staff could describe the roles of accountability in the practice and what actions they needed to take if an incident or concern arose.

A business continuity plan and emergency procedures were in place which had been reviewed, which included details of scenarios they may be needed in, such as loss of data or utilities. Fire drills were held regularly and fire safety checks were carried out.

Emergency medicines, such as for the treatment of cardiac arrest and anaphylaxis, were available and staff knew their location. Processes were in place to check emergency medicines were within their expiry date. A defibrillator and emergency oxygen was available at the practice. Both were checked regularly.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All clinical staff we interviewed were able to describe how they accessed guidelines from the National Institute for Health and Clinical Excellence (NICE) and from local health commissioners. These were received into the practice and disseminated via email by the practice manager.

Treatment was considered in line with evidence based best practice. Clinical meetings with the partners were held monthly to ensure clinicians were kept up to date. All the GP's interviewed were aware of their professional responsibilities to maintain their knowledge and had up to date appraisals. Nurses worked alongside GPs within their guidelines for their area of chronic disease management. GPs maintained lead areas of special interest and knowledge including mental health, cardiovascular and respiratory disease and medicines management.

The practice aimed to ensure that patients had their needs assessed and care planned in accordance with best practice. For instance the practice had a number of patients with drug and alcohol issues. As well as receiving regular health checks they were referred to drug and alcohol support services. The practice also provided support to patients with severe mental health issues living in a nearby residential home. They looked after their general health and welfare needs working in conjunction with specialist mental health practitioners. All over 75s had a named GP.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented. The practice had processes in place to ensure that patients recently discharged from hospital were contacted within three days of discharge to have their care reviewed.

Staff were able to demonstrate how care was planned to meet identified needs using best practice templates, and how patients were reviewed at required intervals to ensure their treatment remained effective. The practice kept up to date records of patients with long term conditions such as asthma, diabetes and chronic heart disease which were used to arrange annual, or as required health reviews. They also provided annual reviews to check the health of patients with learning disabilities and mental illness. National data showed the practice was in line with referral rates to secondary care services for a range of conditions. All GP's we spoke with used national standards for referral, for instance two weeks for patients with suspected cancer to be referred and seen.

The practice also used the computer system to identify patients with specific needs, such as those with dementia or who were in need of palliative care and support. Patients requiring palliative care were discussed at regular multi-disciplinary care meetings to ensure their needs assessment remained up to date.

We saw no evidence of discrimination when making care or treatment choices, with patients referred on need alone.

Management, monitoring and improving outcomes for people

The practice routinely collected information about people's care and outcomes. It used the Quality and Outcome Framework (QOF) to assess its performance and undertook regular clinical audits. Latest QOF data from 2013-14 showed the practice was above the national average for a range of indicators on the management of diabetes and mental health related indicators.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area, for instance the practice looked at A&E admissions and elective admission rates and compared these. This benchmarking data showed the practice had outcomes comparable to other services in the area.

The practice has a system in place for completing clinical audit cycles. Audits had been undertaken on medications. This included an audit of bisphosphonate prescribing to ensure that the correct dosage where being given to patients with chronic kidney disease. The practice had also reviewed its patients on anti-coagulation or anti-platelet therapy to ensure that these were in line with current guidelines. Results of audits were presented back to the practice meeting and medication were reviewed and updated as required.

Clinical staff checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT

Good

Are services effective?

(for example, treatment is effective)

system flagged up when patients needed to attend for a medication review before a repeat prescription was issued, and when people needed to attend for routine checks related to their long term condition.

Effective staffing

Details of staff training were kept on individual staff files as well as on a training matrix maintained by the practice manager. All essential training had been undertaken with training provided external training courses, internal training and e-learning. Staff told us the practice was supportive of relevant professional development.

GP's told us they had undertaken annual external appraisals and had been revalidated or had a date for revalidation, an assessment to ensure they remain fit to practice. Continuing Professional Development for nurses was monitored through the appraisals process. Professional qualifications and medical indemnity insurances were checked and up to date ensuring that clinical staff remained fit to practice.

Staff were appraised annually which generated aims and objectives for staff, with staff able to feed back any problems and what they did well. The recruitment policy showed that relevant checks were made on qualifications and professional registration as part of the process. On starting, staff commenced an induction comprising health and safety, incident reporting and fire precautions, in addition to further role specific induction training and shadowing of other members of staff.

We saw that mandatory training for clinical staff included safeguarding and infection control. Staff also had access to additional training related to their role. Staff said they felt confident in their roles and responsibilities, and were encouraged to ask for help and support, and were able to give examples of when they had asked, for instance, a GP or nurse for additional clinical support if they felt unsure.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases, for instance regular multi-disciplinary meetings were held to identify and discuss the needs of those requiring palliative care or those with mental health needs.

Information from out of hour's services and NHS 111 contacts was disseminated to GPs to review the next working day so that any required action could be taken. The practice kept 'do not resuscitate' and advance decision registers to reflect patient's wishes, and this information was made available to out of hours providers.

Blood results, discharge letters and information from out of hours' providers was generally received electronically and disseminated to doctors for action before the end of the day. These were allocated randomly to ensure GPs had a uniform workload, rather than going to a named GP or the GP who had instigated the referral. The GP recorded their actions around results or arranged to see the patient as clinically necessary.

Information sharing

Information was shared between staff at the practice by a variety of means. There were mutli-disciplinary team meetings and clinical meetings which were attended by both clinical and administrative staff. Staff received information via meeting minutes, the intranet, or emails.

Referrals were completed by direct letters to the local hospital, and these were completed within appropriate protocols. The practice used the Choose and Book system for referrals where possible. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). There was a shared system with the out of hours provider to enable information to be shared in a timely manner and as appropriate. Urgent information could also be sent or received via fax.

Consent to care and treatment

Clinical staff were aware of the implications of the Mental Capacity Act 2005 and were able to describe key aspects of the legislation and how they implemented it, although not all staff had received training.

Where patients with a learning disability or other mental health problems were supported to make decisions, this was recorded. If someone had lasting power of attorney concerning a patient this was recorded on the computer and in the patients plan.

Staff were able to explain how they would deal with a situation if someone did not have capacity to give consent, including escalating this for further advice to a senior member of staff where necessary. Verbal consent was documented on the computer as part of a consultation.

Good

Are services effective?

(for example, treatment is effective)

Written consent forms were used for invasive procedures such as ear syringing or coil fitting, which detailed risks, benefits and potential complications, which allowed patients to make an informed choice.

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

Health promotion and prevention

Advice was given on smoking, alcohol consumption and weight management. Smoking status was recorded and patients were offered advice or referral to a cessation service. Patients over the age of 75 had been allocated a named GP. Nurses used chronic disease management clinics to promote healthy living and health prevention in relation to the person's condition. Patients aged 40-74 were offered a health check in line with national policy, to help detect early risks and signs of some conditions such as heart disease and diabetes. New patients were offered health checks.

In addition to routine immunisations the practice offered flu vaccinations in line with current national guidance. Data showed childhood immunisation rates were in line with national figures.

The practice was able to identify patients with no fixed address or from travelling communities whose attendance for appointments would be erratic. When these patients did attended the practice the clinical staff used the opportunity to undertake opportunistic screening and health checks.

The practice's performance for cervical smear uptake was above the national average. There was a policy to follow up patients who did not attend for cervical smears.

There was a wide range of information and leaflets in the reception area including information on how to access mental health services.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke to five patients during the inspection and two members of the patient participation group. We also collected 40 CQC comment cards which were sent to the practice before the inspection for patients to complete.

The vast majority of feedback collected on the day indicated patients were satisfied with the service provided, that they were treated with dignity, respect and care, and that staff were caring,

professional and approachable. This was in line with comments from the NHS England GP Patient Survey from July 2013 - March 2014 where 84% of patients reported their overall experience as good or very good; this is in line with the national average. The survey also showed higher than average levels of satisfaction for nurses treating them with care and respect and involving them in decisions, 94% and 92% respectively. The practice had also undertaken a survey of patients between July and August 2014 and 84% of the patients who responded rated their overall experience at the surgery as good, very good or excellent.

The reception desk was shielded by glass partitions which helped keep patient information private. A system was in place to encourage patients to approach the desk one at a time, to help prevent patients overhearing potentially private conversations between patients and reception staff. There was a separate room where patients could speak in private if they wished.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were in use in treatment and consulting rooms to maintain patients' privacy and dignity during investigations and examinations. There was a chaperone policy and guidelines for staff, and a poster advertising the service in reception. Nursing staff acted as chaperones where requested.

Care planning and involvement in decisions about care and treatment

The templates used on the computer system for people with long term conditions supported staff in helping to involve people in their care, and nursing staff were able to provide examples of where they had discussed care planning and supported patients to make choices about their treatment.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

People said the GP's explained treatment and results in a way they could understand. They felt able to ask questions and involved in making decisions about their care. Staff told us there was a telephone translation service available for those whose first language was not English and we saw details for this service.

Patient/carer support to cope emotionally with care and treatment

Patients said they were given good emotional support by the doctors. Comment cards filled in by patients said doctors and nurses provided a caring and supportive service.

GP's referred people to bereavement counselling services where necessary, and there was information about support services in reception. Where people had suffered a bereavement, the practice would send a condolence card to the next of kin.

The practice maintained a register of carers, with the information being recorded in patient notes so extra support could be offered. The practice also kept registers of other groups who may need extra support, such as those receiving palliative care and patients with mental health issues, so extra support could be provided.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood and systems were in place to address identified needs. The practice had information both about the prevalence of specific diseases and the specific population groups in the practice area. This information was reflected in the services provided, for example screening programmes, reviews for patients with long term conditions and those with mental health needs. Longer appointments could be made available for those with complex needs, for instance patients with diabetes.

The practice had extended opening hours, until 8:00pm, for appointments every Tuesday which would benefit the working population and parents bringing children outside of school hours. People with caring responsibilities or those in work could also access appointment at a nearby practice on Saturday or Sunday. However the patients we spoke to did not seem to be aware of this service. The GPs would also provide telephone consultations if needed.

The practice was proactive in monitoring those who did not attend for screening or long term condition clinics, and followed these up. The facilities and premises were appropriate for the services which were planned and delivered, with sufficient treatment rooms and equipment available.

Tackling inequity and promoting equality

The buildings accommodated the needs of people with disabilities. All treatment/consulting rooms and patient toilets were on the ground floor. Disabled parking spaces were available. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. There was a hearing loop at reception to assist those hard of hearing and translation facilities were available for those patients whose first language was not English. Where translation services were needed these were automatically allocated a double appointment.

Patient records were noted to highlight to the GPs when someone was living in vulnerable circumstances or at risk so extra support could be offered.

The three salaried GPs at the practice were all female. The practice also employed locums and these were often male GPs, which gave patients to have the choices of seeing a male of female GP. We were told that if a patient raised this as an issue, none had, then access to a male GP from another one of the Intrahealth practices could be arranged.

Access to the service

Patients were able to book urgent appointments by contacting the practice at 8.00am in the morning; alternatively appointments could be booked in advance. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed and details of how to access these were on pre-recorded telephone messages. Appointments could also be booked on line.

Home visits could be made available where required, for instance for those with mobility issues. Repeat prescriptions could be ordered online and this was highlighted on the website.

The practice was open from 8:00am to 6:00pm on Monday, Wednesday, Thursday and Friday. Opening hours on a Tuesday were 8:00am to 1:00pm and 2:00pm to 8:00pm. Patients who were working or had caring responsibilities could also obtain appointments on a Saturday and Sunday. Opening times and closures were advertised on the practice website.

During core times patients could access doctors, nurses and health care assistants. Patients we spoke with told us their appointments generally ran to time. The most common negative comment from patients was the difficulty in getting an appointment. The practice was aware of the issue and was in the process or recruiting two advanced nurse practitioners which would increase the number of appointments available. The first advanced nurse practitioner was due in post at the end of March 2015. The practice needs to monitor the impact when new staff are in post and consider what other options are available to minimise the issue and improve patient satisfaction in this area.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person

Good

Are services responsive to people's needs?

(for example, to feedback?)

who handled all complaints in the practice. Information on how to complain was displayed in reception. Staff were aware of the complaints process and could provide information to patients on it.

We looked at a summary of complaints from the last 12 months, and could see that these had been responded to with a full explanation and apology. The practice summarised and discussed complaints with staff at meetings. Some complaints were also raised as significant events and investigated and changes made to medications or practice. People we spoke to said they would feel comfortable raising a complaint if the need arose.

There was a suggestion box in reception where patients could leave feedback. Patients could also access a link to the Friends and Family Test via the practice website.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice is part of the larger Intrahealth group and shares the Intrahealth mission, vision and values. The practice had a clear vision to ensure that every patient mattered and their personal health needs were fulfilled by caring dedicated teams. The practice was supported by a Head of Primary Care and a Medical Clinical Services Director who reported up to the Intrahealth Board and ensured that the practice was operating in line with the corporate visions and values.

All the staff we spoke to knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff also felt that they were consulted and their opinion was valued.

Governance arrangements

Staff were clear on their roles and responsibilities and were able to communicate with doctors or managers if they were asked to do something they felt they were not competent in. A number of staff had specific lead roles such as infection control and management of specific conditions.

The practice used the Quality and Outcomes Framework (QOF) to measure performance. The QOF data for this practice showed was performing in line or above national standards in most areas, and the practice regularly reviewed its results and how to improve. The practice had identified lead roles for areas of clinical interest and safeguarding. The GPs undertook their own programme of clinical audit. In addition Intrahealth used its corporate staff, such as pharmacists to undertake audits in their practices. Audit results were reported both to staff within the practice and also to the Head of Primary Care and the Medical Clinical Services Director.

Information and learning from incidents and complaints was also evaluated and reported both to staff within the practice and also to the Head of Primary Care and the Medical Clinical Services Director.

Leadership, openness and transparency

Staff said they felt happy to work at the surgery, and that they were supported to deliver a good service and good standard of care. Staff described the culture at the practice as open and honest and said they felt confident in raising concerns or feedback. Our review of the complaints and incidents log confirmed that both administrative and clinical staff had raised issues.

Staff within the practice felt supported by their managers and the GPs there was also a clear corporate organisational structure which set out both organisational and clinical lines of accountability.

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

There was a Patient Participation Group (PPG) and actions were published on the practice website for the practice population to read. This was in the form of a "You say we did" section. Changes made during 2013/14 included a review of the way in which patients who persistently miss appointments were managed and a new procedure, supported by the PPG, to support the management of these patients was introduced.

At the time of the inspection both staff and patients raised concerns about staffing levels and the impact this had on the ability to get appointments. This was being addressed as two advanced nurse practitioners were being recruited.

Members of the PPG also attended regional and NHS England meetings so were able to share ideas and best practice.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We saw that all the doctors and relevant staff were able to access protected learning time where necessary. We saw that appraisals took place where staff could identify learning objectives and training needs.

The practice had completed reviews of significant events and other incidents, and shared these with staff via team meeting discussions to ensure the practice improved outcomes for patients. Staff told us the culture at the practice was one of continuous learning and improvement.