

Fenham Hall Surgery

Quality Report

Fenham Hall Surgery, Fenham Hall Drive,
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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.

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous inspection December 2014 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) – Good

We carried out an announced comprehensive inspection at Fenham Hall Surgery on 20 February 2018. This was as part of our ongoing inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- The practice had improved their approach to postnatal reviews and six-week baby checks. They had introduced a planned approach, which allowed them to easily identify and follow up where families did not attend.
- The practice had improved the support provided to patients reaching the end of their life and this had resulted in more patients dying in their preferred location.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider **should** make improvements are:

- Review the process for recording and documenting fire evacuation drills.

Summary of findings

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

Areas for improvement

Action the service **SHOULD** take to improve

- Review the process for recording and documenting fire evacuation drills.

Fenham Hall Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC lead inspector. The team included a GP specialist adviser.

Background to Fenham Hall Surgery

Care Quality Commission registered Fenham Hall Surgery to provide primary care services.

The practice provides services to approximately 8700 patients from one location, which we visited as part of this inspection:

- Fenham Hall Surgery, Fenham Hall Drive Newcastle Upon Tyne Tyne and Wear NE4 9XD.

The practice website is www.fenhamhallmedicalgroup.nhs.uk.

Fenham Hall Surgery is a medium sized practice providing care and treatment to patients of all ages, based on a General Medical Services (GMS) contract agreement for general practice. The practice is part of the NHS Newcastle Gateshead clinical commissioning group (CCG).

The practice has four GP partners (two male two female). They employ a salaried GP, a practice manager, a nurse practitioner, a practice nurse, a health care assistant and staff who undertake reception and administrative duties.

NHS 111 service and Vocare Limited (known locally as Northern Doctors Urgent Care) provide the service for patients requiring urgent medical care out of hours.

Information from Public Health England placed the area in which the practice is located in the third most deprived decile. In general, people living in more deprived areas tend to have a greater need for health services. Average male life expectancy at the practice is 76.6 years, compared to the national average of 79.2 years. Average female life expectancy at the practice is 81.1 years, compared to the national average of 83.2 years.

76.2% of the practice population were white, 1.9% were mixed race, 18.1% were Asian, 2.1% were black and 1.7% were other races.

The practice had displayed their CQC ratings from the December 2014 inspection, in the practice reception area and on their website, in line with legal requirements.

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

At the last CQC inspection in December 2014, we found the process for storage and recording of blank paper prescriptions, which are carried in doctor's bags in small quantities for home visits, should be reviewed. In February 2018, we found the practice had addressed this concern.

In December 2014, we also found the practice did not document the rationale as to why non-clinical staff did not have disclosure and barring service (DBS) checks. In February 2018, we found the practice had addressed this area and had put in place risk assessments to determine why DBS checks for not required for non-clinical staff. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

In December 2014, The practice told us they had struggled to provide enough nurse sessions over the preceding months. In February 2018, we found the practice had strengthened their nursing team. They now had in place a nurse practitioner, a practice nurse and a health care assistant. They were also supporting a career start nurse within the practice. This had stabilised and increased access to nurse appointments.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite of safety policies, which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.

- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an on going basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.
- There were appropriate arrangements in place to respond in case of a fire. The practice told us they had carried out a whole practice fire evacuation drill within the last twelve months, but were unable to provide documentary evidence of this.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

Are services safe?

- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.

- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, following a significant events the practice made improvements to the way they monitored those patients with mental health conditions who attended the practice regularly to receive medicine. This included a monthly check to identify where patients failed to attend so this could be followed up at an early stage to reduce the risk of a patient's mental health deteriorating.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The practice was a slightly higher prescriber of hypnotic medicines. The average daily quantity of hypnotics prescribed per specific therapeutic group age-sex related prescribing unit (STAR PU) was 0.96. This compared to a clinical commissioning group (CCG) average of 0.68 and a national average of 0.90.
- The practice was a higher prescriber of antibiotics when compared to local and national averages. The number of antibacterial prescription items prescribed per STAR PU was 1.19, compared to a CCG average of 1.07 and a national average of 0.98.
- The practice were monitoring their prescribing of antibiotics and hypnotic medicines, supported by the practice pharmacist, and were taking action to ensure prescribing was generally in line with local and national averages.
- The percentage of antibiotic items prescribed that were Co-Amoxiclav, Cephalosporins or Quinolones was 7.3%, which was in line with the CCG average of 7.4% and the national average of 8.9%. Good antimicrobial stewardship is for broad-spectrum antibiotics like Co-Amoxiclav, Quinolones and Cephalosporins, to be reserved to treat resistant disease.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.

- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The practice achieved high performance across the majority of long-term conditions monitored through QOF, achieving 100% of the points available for 13 of the 19 clinical health domains.
- For indicators relating to asthma, the practice achieved 100% of the points available. This was above the CCG average of 99.4% and the national average of 97.3%.
- For indicators relating to diabetes, the practice achieved 99.2% of the points available. This was above the CCG average of 93.8% and the national average of 91%. For example, the percentage of patients with diabetes, on the practice register, in whom the last blood pressure reading (measured within preceding 12 months) was 140/80 mmHg or less was 85%. This compared to a CCG average of 78.4% and a national average of 78.1%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above. The practice had improved their approach to postnatal reviews and six-week baby checks. They had introduced a more planned approach, which allowed them to easily identify and follow up where families did not attend. As a result of this the practice provided data which showed childhood immunisation rates increased from 93% (in June 2016) to 96% (in December 2017) and pre-school boosters increased from 90% to 92.3% for the same period. The new approach included a dedicated pre-bookable baby immunisation clinic with 15 minute appointment slots. GP were identified to support this clinic, and two nurses were available to help give the baby immunisations safely.

Are services effective?

(for example, treatment is effective)

- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

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

- The practice's uptake for cervical screening was 67.8%, which was below the 80% coverage target for the national screening programme. It was also below the CCG average of 71.0% and the national average of 72.1%. The practice were aware of and had taken action to address this to bring them in line with local and national averages. They had strengthened the nursing team by recruiting new nurses and supported them to receive appropriate training in this area. The practice showed us recent evidence screening rates for the current year had improved and were currently at 75%.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks. However, the practice did not routinely off NHS checks for patients aged 40-74, but where requested would carry these out. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice had been a part of a pilot to improve end of life care. The pilot sought to support improved identification of those patients who would benefit from inclusion on the palliative care register; proactive advanced care planning; and better identification and support for patients to die in their preferred location. This had resulted in improvements to the support provided to patients reaching the end of their life. Data provided by the practice showed from July to December 2015, 63.6% of patients died in their preferred place. As a result of improvements made, this increased to 80% for the period July to December 2017.
- The practice held a register of patients living in vulnerable circumstances including patients from the local bail hostel and those with a learning disability.

People experiencing poor mental health (including people with dementia):

- For the practice, 88.1% of patients with schizophrenia, bipolar affective disorder and other psychosis had a comprehensive agreed care plan documented within the preceding 12 months. This compared to a CCG average of 88.9% and a national average of 90.3%.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review within the preceding 12 months was slightly higher than the national average at 84.2% (compared to a CCG average of 85.4% and a national average of 83.7%).
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, the percentage of patients experiencing poor mental health who had received a recording of blood pressure within the preceding 12 months was 90.1%. This compared to a CCG average of 90.1% and a national average of 90.4%. The percentage of patients experiencing poor mental health who had a record of alcohol consumption within the preceding 12 months was 91.5%. This compared to a CCG average of 91.3% and a national average of 90.7%.

Monitoring care and treatment

Nationally reported data taken from the Quality Outcomes Framework (QOF) for 2016/17 showed the practice had achieved 99.2% of the points available to them for providing recommended treatments for the most commonly found clinical conditions. This was higher than the national average of 97.6% and the local CCG average of 95.5%. (QOF is a system intended to improve the quality of general practice and reward good practice.) The practice had achieved 100% of the points available for 13 of the 19 clinical and for four of the six public health domains within QOF.

The overall exception-reporting rate was 9.8% in comparison to a CCG average of 10.1% and a national average of 9.6%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

The practice used information about care and treatment to make improvements.

Are services effective?

(for example, treatment is effective)

- The practice was actively involved in quality improvement activity. The practice had undertaken eight clinical audits within the last two years. They provided us with two examples of these. For example, the practice had carried out an audit to check the care they provided for atrial fibrillation was in line with national guidelines. (Atrial fibrillation is a condition that causes an irregular, rapid heart rate that may cause symptoms like heart palpitations, fatigue, and shortness of breath). The audit demonstrated an improvement from 85.5% of patients treated in line with guidelines in July 2015, to 99% in July 2016. Other audits carried out included antibiotic prescribing; prescribing of antipsychotics for patients with dementia; and the preferred place of death for palliative care patients.
- Where appropriate, clinicians took part in local and national improvement initiatives. For example, the practice had participated in a local pilot to improve care for patients reaching the end of their life.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- The percentage of new cancer cases (amongst patients registered at the practice) referred using the urgent two-week wait referral pathway was 47.5%. This compared to a CCG average of 48% and a national average of 51.6%. The practice is not an outlier in this indicator.
- Data from Public Health England showed 73.5% of women, aged 50 to 70 years, had received screening for breast cancer within the last three years. This compared to a CCG average of 72.8% and a national average of 70.3%. Of all patients aged 60-69, 51.1% had received screening for bowel cancer in last two and a half years. This compared to a CCG average of 57.6% and a national average of 54.5%.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

Are services effective?

(for example, treatment is effective)

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 19 patient Care Quality Commission comment cards we received were positive about the service experienced. This is in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the National GP Patient Survey published in July 2017 showed patients felt they were treated with compassion, dignity and respect. There were 339 survey forms distributed for Fenham Hall Surgery and 115 forms returned. This was a response rate of 33.9% and equated to approximately 1.3% of the practice population.

The practice was above averages for its satisfaction scores on consultations with GPs and nurses. For example, of those who responded:

- 96% said the GP was good at listening to them; (clinical commissioning group (CCG) – 91%; national average – 89%).
- 95% of patients who responded said the nurse was good at listening to them; (CCG – 94%; national average – 91%).
- 96% said the GP gave them enough time; (CCG - 90%; national average - 86%).
- 91% of patients who responded said the nurse gave them enough time; (CCG - 95%; national average - 92%).
- 100% said they had confidence and trust in the last GP they saw. (CCG – 97%; national average – 96%).
- 98% said they had confidence and trust in the last nurse they saw; (CCG - 98%; national average - 97%).
- 92% said the last GP they spoke to was good at treating them with care and concern; (CCG – 90%; national average – 86%).

- 92% said the last nurse they spoke to was good at treating them with care and concern; (CCG – 93.1%; national average – 90.7%).
- 83% said they found the receptionists at the practice helpful; (CCG - 88%; national average - 87%).

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. Patients were also told about multi-lingual staff who might be able to support them.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 171 patients as carers (2% of the practice list).

- A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective.
- Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Results from the National GP Patient Survey we reviewed showed patients responded mostly positively to questions about their involvement in planning and making decisions about their care and treatment and results when compared with local and national averages. For example, of those who responded:

- 92% said the last GP they saw was good at explaining tests and treatments; (CCG - 89%; national average – 86%).

Are services caring?

- 91% of patients who responded said the last nurse they saw was good at explaining tests and treatments; (CCG – 92%; national average – 90%).
- 84% said the last GP they saw was good at involving them in decisions about their care; (CCG – 86%; national average – 82%).
- 84% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; (CCG – 89%; national average – 85%).

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services across all population groups.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. (For example extended opening hours, online services such as repeat prescription requests, advanced booking of appointments, advice services for common ailments.)
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, most consultation rooms were downstairs and easy to access for those patients with mobility disabilities. The room used by the counsellor was upstairs, but where patients found it difficult to use the stairs, consultations were arranged in a room on the ground floor.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice linked to a local care home, which was also part of a local pilot to ensure good access to healthcare for residents and reduce avoidable admissions. We spoke with members of the extended community healthcare team involved with the pilot. They told us practice staff went above and beyond to meet the needs of residents of the care home. They told us practice staff visited the care home on a weekly basis to review the needs of patients, and ensure comprehensive care plans

were in place and reviewed regularly. They told us there was very good team work with the practice in meeting the needs of residents of the care home, who were also patients of the practice.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- The practice had improved their approach to the recall for the six-week baby check-up and childhood immunisation process. Previously, the practice had adopted a drop in clinic. This made it difficult to plan and sometimes led to long waits for families. There were no pre-booked appointments; no list of babies expected; or, formal mechanism to chase up those who did not book in. There was a risk this could result in delayed or missed immunisations. The practice identified this as an area for improvement and implemented a new approach. This was developed in conjunction with health visitors and included increased identification of babies prior to the six-week check (by encouraging the family to register the child as a patient of the practice and the health visitor sharing earlier a list of babies born in the area); the practice sending out invites for appointments; and improved and earlier follow up where families failed to attend. Staff and patients had provided the practice with positive feedback about this approach.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment.

Are services responsive to people's needs?

(for example, to feedback?)

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, they offered extended opening hours.
- The practice had increased the number of same day appointments to meet the needs of students, younger patients and those who did not speak English as a first language. They provided 30 minor ailment slots to be booked on the day.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including patients from the local bail hostel and those with a learning disability.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients who failed to attend were proactively followed up by a phone call from a GP.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.

Generally, the National GP Patient Survey published in July 2017 showed patients were satisfied with the service they received. For the practice, 85% of patients who responded were satisfied with their overall experience of the GP surgery. This was slightly lower than the local clinical commissioning group (CCG) average (of 87%) and the same

as England average of 85%. Although patients were generally satisfied, there were some below average results relating to access to appointments. For example, of those who responded:

- 80% of patients were satisfied with opening hours. (CCG - 84%; national average - 80%).
- 73% found it easy to get through to this surgery by phone. (CCG - 77%; national average - 71%).
- 69% were able to get an appointment to see or speak to someone the last time they tried. (CCG - 75%; national average - 76%).
- 72% said the last appointment they got was convenient. (CCG - 81%; national average - 81%).
- 64% described their experience of making an appointment as good. (CCG - 75%; national average - 73%).

At the last CQC inspection, in December 2014, we found some patients had reported difficulty in accessing appointments. The practice had strengthened the nursing team to address previous concerns about access to nurse appointments. The practice had also identified a potential unmet need in their practice population, which would benefit from same day access. They had high numbers of students and patients whose first language was not English and 27% of their patients were aged under 18. They increased on the day appointment availability by recruiting an nurse practitioner and providing 30 minor ailment slots to be booked on the day. The on-call GP no longer had any pre-booked appointments, and this freed them up to undertake early home visits and see patients with urgent mental health needs. Appointment times increased from 10 to 15 minute intervals to give more time for GPs to help with complex patient needs. The practice told us as a result of the changes made under 18 A&E attendances reduced by 21% for the period December 2016 to December 2017.

The practice also had access to appointments as part of a hub approach, where if all appointments for the day were full they could trigger referral of patients to the local walk-in centre. This reduced the risk of patients using other emergency services inappropriately, such as A&E.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

Are services responsive to people's needs? (for example, to feedback?)

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Three complaints were received in the last year. We reviewed two complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, extra training and briefing was provided to staff following a complaint about customer service.

Are services well-led?

Good 

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Since the last inspection in December 2014, the practice had focused on workforce planning and development of a team culture. This had included ensuring the right skills mix to support the practice into the future. Since the last inspection, they had recruited a nurse practitioner, practice pharmacist and an experienced health care assistant. They were also supporting a career start nurse, in conjunction with another practice.

They had introduced a staff recognition scheme and length of service award. They had increased team involvement in decisions about the practice by supporting regular staff meetings, with active team involvement. The practice used virtual surgeries for clinical, safeguarding and palliative meetings to allow staff to log issues (including patient concerns) to be discussed if they were not able to attend directly. This ensured these were not missed.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The practice told us about an example, where following a significant event, a GP who knew the person contacted them to explain what had happened and apologised for the error made. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

Are services well-led?

Good 

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of patient safety and medicine alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.

- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
- Engagement with patients, the public, staff and external partners
- The practice involved patients, the public, staff and external partners to support high-quality sustainable services.
- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was an active virtual patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. The practice was part of a pilot to identify and understand the needs of patients reaching the end of their life and delivered care in a way that meet their needs. They were also a part of an initiative to ensure the healthcare needs of residents of a local care home were met.
- Staff knew about improvement methods and had the skills to use them. For example, the practice used a stop, start and amend exercise to help them identify and move non-clinical work undertaken by the GPs to the administration team, to support GPs to have more time to see patients.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.