Friarsgate Practice

Quality Report

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

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 inspected this service on 16th October 2014 as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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

Our key findings were as follows:

• Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.

• The practice could demonstrate improved outcomes for patients through the use of a comprehensive range of clinical audits.

• The partners provided strong and clear leadership which had led to a committed and motivated staff group.

• The practice was responsive to its different patient groups and patients were satisfied with the service they received.

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 was rated as good for safe.

Patients we spoke with and those that had completed comment cards said they felt safely cared for and had no concerns about their care or treatment.

The practice had comprehensive safeguarding policies and procedures to safeguard vulnerable patients. The practice had a designated safeguarding lead who had received relevant training. All practice staff had been trained in safeguarding vulnerable adults and children. Significant events had been discussed at team meetings and we saw that learning and actions had taken place to reduce the risk of further occurrences.

Equipment used in the delivery of care had been appropriately maintained and tested. The building and equipment had been subjected to relevant safety checks and certified. The practice had a robust medicines management system. The practice had a service continuity plan to deal with emergencies which could interrupt the running of the practice.

Are services effective?

Good

The practice was rated as good for effective.

Patients experienced an effective practice. Care and treatment was provided in line with evidence based practice and national agreed guidelines.

We found that there were processes to monitor the delivery of treatment. Clinical audits were used to review and improve outcomes for patients. We noted that the performance in the Quality and Outcomes Framework (QOF) report for 2012 to 2013 showed that the practice achieved a total of 99.2%. This was above the average for practices in England.

There were processes for managing staff performance and professional development via an appraisal system. We found the practice had processes for multi-disciplinary working, with other health care professionals and partner agencies.

Are services caring?

Good

The practice was rated as good for caring.

Summary of findings

The GPs and staff we spoke with demonstrated a caring approach. Patients were positive about the care they received. This was reflected in the local patient survey, on comment cards CQC reviewed and with patients we spoke with on the day of the inspection.

We found that patients' needs were assessed and the care and treatment provided was discussed with patients and delivered to meet their needs. The practice managed patient information and data confidentially ensuring it was held securely.

End of life care was led by a named GP for each patient.

Are services responsive to people's needs?

Good

The practice was rated as good for responsive.

We found that the practice was responsive to patients' needs. The practice, along with the support of their patient participation group, enabled patients to voice their views and opinions in relation to the quality of the services they received.

Information about how to complain was made readily available to patients and other people who used the practice (carers, visiting health professionals). Complaints were appropriately investigated and responded to in accordance with the practice's complaints policy.

Are services well-led?

Good

The practice was rated as good for well-led.

We found that the management team provided open, inclusive and visible leadership to the staff.

There were governance arrangements to continuously improve the practice. To ensure improvements were made, both patients and staff were encouraged to be actively involved in the quality monitoring of the services provided.

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 was rated as good for the care of older people. Each older patient had a named GP. The practice promotes wellness clinics for older patients to manage their own health and well-being and promoted a walking group on its website. Carer status was regularly checked to ensure their needs and the needs of the patient had been met. If a patient was known to have mobility issues and struggled to attend the practice, nurses arranged home visits if urgent care was required.

Patients who required end of life care were supported by a team of health professionals. This included district and Macmillan nurses. The named GP lead on the care required by each individual and ensured continuity of care by responding to out of hours calls directly themselves for their allocated patients.

People with long term conditions

Good

The practice was rated as good for the care of patients with long term conditions. Regular reviews were arranged for patients with conditions such as asthma and chronic obstructive pulmonary disease (COPD) and diabetes. These reviews ranged from three monthly to six monthly depending on the individual patient.

We saw on the practice website and in the patient waiting room that leaflets and guidance were available to patients on how to manage their condition. This included links to the local council's active lifestyle scheme which allows GPs to refer patients to a variety of activities such as swimming and active lifestyles.

The practice nurse followed up patients with long term conditions that had been admitted to hospital. This enabled the practice to review the reason for admission and to review their current treatment needs, which was aimed at reducing the reoccurrence of hospital admission.

Families, children and young people

Good

The practice was rated good for the care of families, children and young people. The practice treated children and young people in an age appropriate way. This included seeking consent appropriately depending on their age. For example, offering teenage children appointments in confidence and independently from their family where appropriate.

The practice had a system to identify children or parents at risk and the process had been applied as needed.

Summary of findings

Antenatal and baby immunisation clinics were offered to babies and GPs carried out the babies first immunisations with practice nurses carrying subsequent immunisations. The practice had a close working relationship with community midwives and health visitors.

Working age people (including those recently retired and students)

Good

The practice was rated as good for the care of working age patients. A number of clinics and services to promote good health and wellbeing were available for all patients. Emergency appointments, telephone consultations, and extended evening clinics until 8pm on a Monday, Tuesday and Thursday to accommodate people working between the hours of 9am and 5pm were also available. Repeat prescription requests were available in person and on-line. Patients were also able to cancel an appointment either in person, by phone or on line.

Health promotional information was available to patients on the practices website and the patients waiting areas. For example, smoking cessation advice.

People whose circumstances may make them vulnerable

Good

The practice was rated good for the care of patients living in vulnerable circumstances. The practice had systems to identify patients, families and children who were at risk.

The practice worked closely with other health and social care professionals to provide a support network for vulnerable patients. We saw evidence of joint working with families and professionals to assist a patient and maintain their safety and independence in the community.

The practice had an identified lead for safeguarding and we saw from training records that staff had been appropriately trained in safeguarding vulnerable adults and children. The practice had a safeguarding policy and procedure. Staff were familiar with how to report any safeguarding concerns.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for the care of patients experiencing poor mental health. The health professionals at the practice knew how to refer on patients with complex health needs. The practice had also invited other health professionals to practice meetings when appropriate.

All staff, including reception staff were encouraged to report any concerns they may have.

Summary of findings

Patients on regular medication were regularly reviewed and relevant information shared with other health professionals and agencies involved the patients' care. In the waiting area patients were given information about other services for example, counselling.	

Summary of findings

What people who use the service say

We spoke with 15 patients and four members of the patient participation group. We reviewed 12 CQC comment cards that patients had completed.

The patients we spoke with were all happy with the care and treatment they had received. Patients knew they could have someone with them at their consultation if they wished. They also knew they could speak in a private area should they require to. Most patients were happy with the appointment system. Patients told us they were happy with the facilities and cleanliness of the practice.

Patients told us they were involved in their treatment plans and always treated with dignity and respect. One comment card we reviewed was positive about the helpfulness of GPs and nurses stating they went beyond the expectations of the patient.

The last patient survey carried out in 2013-2014 showed that patients found the GPs and nurses at the practice approachable and easy to talk with.

Friarsgate Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Friarsgate Practice

Friarsgate practice provides primary medical services under a general medical services contract between the practice and NHS England. As part of West Hampshire Clinical Commissioning Group they are responsible for a population of more than 24,600 within Winchester and surrounding villages. The female population is slightly higher than the male at 52.13%. The largest group 67.6 % are between the ages of 17 – 65. 16.37 % are over the age of 65.

There are 12 GPs and four associate GPs, four nurses and two health care assistants. There is a practice manager, their deputy and other administrative staff at the practice.

The practice offers an evening surgery on Monday, Tuesday and Thursday until 8pm for those unable to attend during the hours of 9am to 5pm. The practice does not offer out-of-hours services to their patients and patients are sign posted to other out-of-hours services.

The practice offers online services including ordering repeat medication and booking routine appointments. Patients could also update personal details on line, for example, a change of address.

The practice also offers services from two other locations which were not visited as part of this inspection –

Badger Farm SurgeryBadger Farm RoadBadger FarmWinchesterSO22 4QB

Kings Worthy Surgery40 Pound RoadKings WorthyWinchesterSO23 7PU

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew including the local Healthwatch, clinical commissioning group and NHS England. We carried out an announced visit on 16 October 2014. During our visit we spoke with a range of staff including GPs, Nurses, administrative staff and the practice manager. We spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Detailed findings

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
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable

People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, one staff member explained the procedure that the practice followed when raising a safeguarding alert. They described the steps they took in raising a safeguarding children's concern with the local authority and discussing their concern with the practice lead for safeguarding children.

Information was looked at from the Quality and Outcomes Framework (QOF), which is a national performance measurement tool 2012-2013. The QOF showed that the provider was appropriately identifying and reporting significant events. The practice manager told us they completed incident reports and significant event had been analysed by the practice management team.

The practice had a system for reporting, recording and monitoring significant events. We saw that practice meetings minutes for the past two years, evidenced that significant events and changes to practice were discussed with all practice staff. Including the nurses and administration staff if appropriate. We saw actions had taken place to reduce the risk of recurrence in the future. The GPs and practice manager completed evaluations and discussed changes the practice could make to enable better outcomes for their patients. If it was deemed necessary, events and lessons learned were shared with multi-professional agencies outside the practice.

All staff we spoke with knew how to escalate any incidents. Staff including nurse administrative and GPs knew the forms to complete and report the incident to the practice manager.

Significant events we reviewed showed the date the event had been recorded, a description of what happened, what had been done well and what could be done differently to reduce a re-occurrence. We saw evidence that the practice had reviewed how it offered first appointments when a patient is new to the practice and not yet registered. This allowed patients to make an appointment and see a GP before completing their registration paperwork.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last 12 months and these were made available to us. A slot for significant events was on the practice meeting agenda and a dedicated meeting had occurred at least three monthly to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. All Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Once an incident form had been completed it was sent to the practice manager who showed us the system they used to oversee these were managed and monitored appropriately. We tracked two incidents and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example,

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at clinical meetings such as nurse meetings or the practice partners meeting to ensure all relevant staff were aware of any relevant changes to the practice and where required discussed action that needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had safeguarding policies and procedures to help protect children and vulnerable adults. These were up to date and all staff knew where to locate them. Contact details for the local authorities safeguarding teams for both children and adults were clearly displayed for staff to use along with a flow chart for reporting concerns.

One of the GPs was the safeguarding lead for the practice and all clinicians had been trained to level three for safeguarding children and vulnerable adults. We saw

evidence that were a concern had been raised the practice had followed its own procedures and raised a concern with the local authority. There was a system in place to highlight vulnerable patients on the electronic patient record system. This made staff aware of any relevant issues when a patient attended their appointment. For example, we saw that a child's recorded was highlighted as being subject to a children's protection plan.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

The practice had a chaperone policy and reception staff knew the service was available. Staff had been suitably trained and understood their responsibilities when acting as chaperones including where to stand to be able to observe an examination of a patient.

Medicines management

The practice had a procedure for repeat prescriptions. This was in line with national guidance. This included how staff who dealt with repeat prescriptions was trained and how changes to prescriptions were managed. This included the reviewing of medicines to ensure they were still required and safe.

We checked medicines stored in the treatment rooms and medicines refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. We saw that the practice had a procedure for managing vaccines and maintaining the cold chain. This included regular recording of temperatures of the refrigeration units and staff knew the actions to take should a unit fail.

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

There was a clear procedure for the reviewing and re-ordering of these medicines. If patients needed foreseeable emergency treatment, the practice had appropriate medicines and equipment to respond to this.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and received regular supervision and support in her role as well as updating in the specific clinical areas of expertise for which she prescribed. For example, we saw evidence that had attended relevant courses within the last year and saw notes of supervision sessions that had been held with one of the partners in the practice.

The practice did not hold controlled drugs or dispense medicines from the practice. There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

Cleanliness and infection control

The practice nurse was the lead for infection control. Staff told us that hand washing and infection control training had been undertaken by staff within the practice.

We saw that liquid hand wash and disposable towels had been provided in the public toilets. Information about hand hygiene and the importance of washing hands was on display in public areas.

Clinical/treatment rooms had clinical waste bins, along with liquid soap and disposable paper towels. The curtains used in clinical rooms were disposable and there was a schedule in place for routinely changing them.

We saw that a legionella risk assessment had been carried out annually the last assessment had been carried out in November 2013. Areas of low use had cold taps run weekly and the water temperature in all hot taps was checked weekly.

Equipment

Good

Are services safe?

The practice had contracts for annual checks of fire extinguishers, portable appliance testing and calibration of equipment such as spirometers to measure lung capacity and nebulisers used to help breathing. These were maintained to International Organisation Standardisation (IOS) guidelines.

Vaccines were appropriately stored in refrigerators specific for that purpose. The refrigerator temperatures were checked twice daily and we saw logs to ensure that these were within acceptable limits. There was a maintenance log and a record noted when faults were identified and parts required replacement or repair. We saw evidence that portable appliance testing had been undertaken and was up to date and that calibration of equipment had been carried out where necessary.

Staffing and recruitment

There were clear policies describing how the practice ensured the recruitment of staff was safe. Staff told us about pre-employment checks undertaken, including disclosure and barring service checks (DBS) and references. We reviewed a random selection of staff files to see if this system had been followed. We found that staff files contained the necessary information and checks.

We spoke with the staff about staffing levels within the practice. They told us there were strategies for the clinical team to safely cover staff shortages and absences with minimal or no use of locum or agency staff. There were sufficient staff at the practice and patients did not have any difficulties accessing a GP or nurse appointment. Patients told us they never had to wait for long periods of time, unless they had requested to see a specific GP or nurse.

Monitoring safety and responding to risk

There were systems to monitor the safety of the practice and respond to identified risks. This included regular assessment and audit of the equipment, environment, and medicines. We saw evidence that these checks were carried out at various timescales ranging between weekly, monthly and yearly depending on national guidance regulatory law.

The practice employed a facilities person to carry out many of the environmental checks and complete small maintenance tasks on the building.

The practice had an accident and incident book. All staff we spoke with knew where this was located and how to complete the paperwork appropriately. Staff told us that all incidents and accidents were recorded and reviewed to see what actions if any could be taken to minimise a re-occurrence. These were discussed at staff meetings and any outcomes shared with all staff.

Arrangements to deal with emergencies and major incidents

The practice manager was responsible for dealing with scheduled or unscheduled absences of staff. Staff had worked at the practice for a long period. This resulted in staff having multiple skills that enabled them to cover absences and ensure the practice was able to continue to function safely. We checked the emergency medicines and saw that they were stored appropriately and all were in date.

The practice had emergency and business continuity plans that highlighted situations which would present risks to patients and the practice such as computer system failure, telephone breakdown and loss of utilities or floods.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and any required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff worked and treated in line with NICE guidelines. We saw thorough assessments of patients' needs and that these had been reviewed when appropriate. For example, staff regularly monitored patients who had been treated for diabetes. This included regular reviews of the treatment plan to ensure the patient received the optimum care.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with worked collaboratively and openly, asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. The review of the clinical meeting minutes confirmed this happened.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients. For example patients with suspected cancers had been referred and seen within two weeks. We saw minutes from meetings where a regular review of elective and urgent referrals was made, and that improvements to practice were shared with all clinical staff.

Patients we spoke with told us they received care and treatment appropriate to their needs. They told us they were involved in deciding on the treatment they required.

Management, monitoring and improving outcomes for people

The practice has a system in place for completing clinical audit cycles. Examples of clinical audits included chronic obstructive pulmonary disease (COPD) which mapped the patient journey and the practice reviewed the care pathway for patients with this condition. Including referrals to secondary care. GPs undertook minor surgical procedures in line with their registration and NICE guidance. The staff had appropriate training and kept up to date with the training required for their role and professional registration. We saw evidence of this in their individual staff files. They also carried out regular clinical audits on their results and used them as evidence towards their individual appraisals.

The practice reviewed patients under a national enhanced service to minimise admissions to hospital. Where gaps in service provision were found action was taken so as to improve the patient experience. For example patients were signposted to other agencies who could be contacted prior to attendance at accident and emergency departments.

Regular clinical meetings took place with multi-disciplinary attendance to share information and provide reflection and learning to the benefit of the patients. We saw evidence of collaborative working with a hospital consultant about treatment for long term conditions that resulted in a positive outcome for the patient concerned.

Effective staffing

All the staff at the practice felt they had been offered appropriate training opportunities relevant to their role. Staff undertook mandatory training to help ensure they were competent in the role they were employed to undertake. In addition to this they were encouraged to develop within that role, and sometimes into other roles more suitable to the requirements of the practice. Most staff had multiple skills and felt able to carry out the roles of their colleagues.

The practice had an induction process this covered the practice ethos, duty of care and practice policies and procedures.

GPs and nurses went through continuous professional development and all GPs had been revalidated. All qualified nurses had current registration with the Nursing and Midwifery Council. The practice had carried out annual appraisals on all staff last year. These were slightly over due

Are services effective?

(for example, treatment is effective)

this year, because the practice had installed a new computer system within the practice. The practice was aware of this and had a plan to carry staff appraisals over the coming few months.

Patients we spoke with felt that staff were competent and knowledgeable and carried out their role well. During the inspection we observed staff carrying out their roles in an effective and caring way.

Working with colleagues and other services

All staff worked together to deliver an effective service to patients. The practice staff worked collaboratively with other health professionals and agencies to provide holistic care to patients. Minutes of clinical meetings showed that district and Macmillan nurses attended these meetings to discuss the needs of palliative patients registered with the practice. This evidenced good information sharing and integrated care for those patients at the end of their lives.

The practice had signed up to the Hampshire Health record. This contained information extracted from the GP record that allowed other clinical staff such as district nurses, community health staff access to relevant information about a patient's current health needs and treatment.

Information that came into the practice such as letters or blood results was scanned on to the computer system and sent to the appropriate GP for review and action if required. This information was shared with other clinicians within the practice where appropriate.

Information sharing

The practice held a variety of meetings to enable information sharing. These included clinical meetings, management meetings and practice meetings involving all staff. Patient records and information was regularly updated and shared with the out of hour's service (OOH) and the practice updated its patient record regarding any treatment a patient received form the OOH service during the evening or at weekends. This ensured the practice maintained up to date patient records. At the practice meetings information on risks and significant events were shared and discussed openly. Staff had been kept updated on families and or children at risk that were registered with the practice. Minutes of these meetings were kept and available to any staff that had not been able to attend the meeting.

There was a practice website with information for patients including signposting, services available and latest news. There were also information leaflets available within the practice waiting room.

Consent to care and treatment

Patients we spoke with told us they received care and treatment appropriate to their needs. They told us they were involved in deciding on the treatment they required.

The practice had a policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how that consent should be recorded.

GPs and nurses told us how the practice managed patients that lacked capacity to consent to specific treatment. They said that mental capacity assessments were carried out by the GPs or nurses and recorded on individual patient records. Staff had received training in the Mental Capacity Act 2005 and 'best interest decision making' to ensure they had the necessary knowledge and skills to use in practise.

GPs referred to the Gillick competency (used in medical law to decide whether a child 16 years or younger is able to consent to his or her own medical treatment without the need for parental permission or knowledge) when assessing young people's ability to understand or consent to treatment. Patients' rights and wishes were considered at the same time as making sure the treatment they received was appropriate.

A patient told us of when they were able to support their child in to one appointment and was reassured that the GP explained the procedure well so that the patient could make their own decision and the parent knew how they could support their child after the procedure.

Health promotion and prevention

New patients underwent a new patient registration process. This gave the patient information about the practice, record keeping and consent. It also gathered information in respect of the patient's individual needs, such as their main spoken language, if they were a carer, the patient's ethnicity and if they had a disability. During this time patients were given an initial consultation which provided an opportunity for a health check and also to offer health promotion advice and information.

Are services effective?

(for example, treatment is effective)

Patients we spoke with that had long-term conditions told us they were invited for regular reviews of their condition and medicines, usually by letter.

The practice website and surgery waiting areas provided various up to date information on a range of topics and health promotion literature including vaccinations for example, flu and holiday vaccines was readily available to support people considering any change in their lifestyle.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients we spoke with and those who completed comment cards told us that they found staff at the practice polite and considerate. Comments from patients were positive in relation to staff as well as the care and treatment that they had received. During the inspection we saw that privacy during consultations was observed with doors kept closed. Clinical staff told us they always used curtains and blinds to maintain patients' modesty when required.

The practice had a patients' charter which outlined the service patients could expect. Patients told us that they felt this was followed by all staff. The most recent practice patient questionnaire showed a high level of satisfaction with the service provided and the attitude of staff towards patients. The practice induction described medical ethics in detail and all staff had completed e-learning around dignity and respect.

We found that there were systems to ensure that patients' privacy and dignity were protected at all times. The practice had a confidentiality policy that detailed how staff should protect patients. Staff we spoke with knew of their responsibilities in maintaining patient confidentiality. Staff had also received training in information governance as part of their statutory training to ensure staff accessed, used and shared patient information appropriately.

Care planning and involvement in decisions about care and treatment

We looked at how the practice involved patients in the care and treatment they received. We found that patients' involvement in care and treatment was appropriate. Patients we spoke with said they felt listened to and included in their consultations. They told us they felt involved in the decision making process in relation to their care and treatment, and that GPs and nurses took the time to listen to them, as well as explain all treatment options. Patients said they felt they were able to ask questions if they had any. We were told by staff that patients could see the GP of their choice.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with on the day of the inspection and six of the comment cards we reviewed stated that they felt well supported by all staff at the practice. Patients told us they were given enough time during their consultation to ask questions and discuss any concerns they may have regarding their treatment.

All GPs told us that they supported patients to cope emotionally with their treatment. This included longer consultation if required and offering support the family as well as the patient. One patient gave an example of how a GP had supported their partner and them through their treatment, explaining everything clearly so they understood what was happening and what to expect.

Patients who required end of life care were supported by a team of health professionals. This included district and Macmillan nurses. The named GP lead on the care required by each individual and ensured continuity of care by responding to out of hours calls directly themselves for their allocated patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Our findings

Responding to and meeting people's needs

We found that the practice was responsive to patients' needs. The practice, along with the support of their patient participation group (PPG), enabled patients to voice their views and opinions in relation to the quality of the services they received. The PPG is a group of volunteers who work together with the practice to improve services and promote health and improved quality of care.

PPG meetings had been conducted to discuss terms of reference and the purpose of the group. Regular meetings had taken place to ensure patients views and opinions were discussed and considered. We saw that the practice had a website containing a section dedicated to the PPG, where the latest annual report could be accessed by patients and members of the public. Patients' views were listened to and considered in relation to the quality of the services they received.

GPs and nursing staff we spoke with told us there was a wide range of services and clinics available to support and meet the needs of the varied patient population groups. They told us they referred patients to community specialists or clinics, when appropriate. Examples of this were referring older people or their carers to groups who specialised in supporting patients and carers with dementia as well as referring mothers with babies or young children to the health visitor.

Patients who required end of life care were supported by a team of health professionals. This included district and Macmillan nurses. The named GP lead on the care required by each individual and ensured continuity of care by responding to out of hours calls directly themselves for their allocated patients.

Tackling inequity and promoting equality

Staff reported that there was little diversity within their patient population. Staff had knowledge of language issues and knew how to access interpreter services when they were required. However, there was a growing population of patients from eastern Europe and staff told us that the practice was aware that it may need to access interpretation services more frequently in the future in order to fully meet their needs. Staff had knowledge on issues relating to culture and ethnicity. They demonstrated an understanding of how to be respectful of patients' views and wishes.

An audio loop was available for patients who were hard of hearing and staff were knowledgeable about the different needs of the patients who attended. There was disabled toilet access and baby changing facilities were available.

Access to the service

The practice was all on one level and accessible by wheelchair. The appointment system allowed for same day emergency appointments for patients. Home visits were arranged, where appropriate, by both GPs and practice nurses. Patients living in care homes were covered by a named GP to ensure continuity of care.

The practice offered extended evening appointments three days per week and at certain times offered Saturday clinics for flu vaccinations.

There were arrangements with another provider to deliver services to patients outside of Friarsgate Practice's working hours that patients accessed by telephone.

Listening and learning from concerns and complaints

The practice has a system for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints received by the practice. There was information available to guide patients on the action to take if they wished to raise a complaint, this included information on how to contact the ombudsman. This gave patients the option of taking their complaint further if they were not happy with the way in which the practice responded.

We looked at the records of recent complaints received. Detailed information was recorded including the outcome of the investigation. We saw that the practice responded appropriately to complaints and concerns raised by patients.

We were told that complaints had been discussed at practice meetings. We looked at minutes of staff meetings

Are services responsive to people's needs?

(for example, to feedback?)

and saw that complaints had been discussed and that lessons were learnt. Staff told us the practice had an open approach to complaints and that information was shared with all staff.

Tackling inequity and promoting equality

Staff reported that there was little diversity within their patient population. Staff had knowledge of language issues and knew how to access interpreter services when they were required. However, there was a growing population of patients from eastern Europe and staff told us that the practice was aware that it may need to access interpretation services more frequently in the future in order to fully meet their needs. Staff had knowledge on issues relating to culture and ethnicity. They demonstrated an understanding of how to be respectful of patients' views and wishes.

An audio loop was available for patients who were hard of hearing and staff were knowledgeable about the different needs of the patients who attended. There was disabled toilet access and baby changing facilities were available.

Access to the service

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Are services well-led?

Good

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

Our findings

Our findings

Vision and strategy

The practice manager and GP partners provided visible, supportive and clear leadership. This was evident from comments from patients, staff and our observations in discussion with them. All staff we spoke with told us there was an open, transparent and supportive culture at the practice, and an expectation of high standards of service delivery. Staff told us they were able to ask any question, raise concerns and make suggestions and that they were listened to and responded to. We saw there was a document explaining expected standards of work and behaviour for staff.

The whole practice team had shared visions and values. The comments from staff and patients showed the GPs advocated strongly for their patients to ensure their health and wellbeing were protected. Interviews with staff and the patient participation group (PPG) indicated that the practice manager and GP partners worked collaboratively with others, both internal to the practice and externally, to continually improve their service. Staff we spoke with told us they felt there was an open door culture within the practice, they felt appropriately supported and were able to approach senior staff about any concerns they had.

Governance arrangements

We looked at the governance arrangements at the practice and saw that these included the delegation of responsibilities to named GPs, for example, as lead for safeguarding, prescribing and minor surgery. We saw that the lead roles provided structure for staff in knowing who to approach for support and clinical guidance when required.

Staff we spoke with told us there was a clear management structure that included allocations of responsibilities. The policies and procedures underpinning all areas of the service provided at the practice were up to date and clear. These documents provided guidance for staff who confirmed the documents were accessible to them.

Leadership, openness and transparency

We found that both GPs carried out peer reviews and clinical audit cycles. This supported them in respect of their revalidation as well as making improvements and developments at the practice. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise.

We saw that the practice had a quality assurance policy with an identified quality assurance lead person.

All staff at the practice received annual appraisals. These gave staff an opportunity to discuss their objectives, any improvements that could be made and training they needed or wanted to undertake.

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

Patients we spoke with said they felt happy and able to feedback concerns, complaints and any compliments they had about the practice to any staff member.

PPG representatives we spoke with during our visit told us the management team were open and responsive to suggestions. They said that the practice carried out regular patient surveys to consider ways to improve the services provided.

Staff told us they welcomed patient feedback and we saw that any concerns raised by patients were documented and responded to appropriately.

Management lead through learning and improvement

The GP partners and practice manager showed a clear understanding that all staff had access to learning and improvement opportunities.

Existing staff had training needs identified at their annual appraisal. Mandatory training for all practice

Are services well-led?

Good

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

staff was role dependent. Training was provided in different ways including e-learning on the internet. New staff went through an induction process which included core and mandatory training.

GPs and qualified nurses kept their continuous professional development up to date and attend courses relevant to their role or area of special interest.