Fenham Hall Surgery

Quality Report

Fenham Hall Drive, Newcastle Upon Tyne, Tyne and Wear, NE4 9XD
Tel: 0191 274 3724
Website: www.fenhamhallmedicalgroup.nhs.uk

Date of inspection visit: 3 December 2014
Date of publication: 05/03/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Fenham Hall Surgery on 3 December 2014.

Our inspection team was led by a CQC Inspector and included a GP specialist advisor. We have rated the practice overall as good.

Our key findings were as follows:

- Patients we spoke with told us they were generally satisfied with the care provided by the practice and said their dignity and privacy was respected.
- Patient outcomes were either in line with, or better than average, when compared to other practices in England.
- The practice had good working arrangements with other healthcare professionals to share information and improve patient care.
- Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. We saw they were appropriately supported through training and appraisals.
- There was a range of qualified staff to meet patients' needs and keep them safe.

There was an area of outstanding practice;

- The practice were one of the first practices in the area to take on a young apprentice as a member of the administration staff. This was successful and started the process for other practices to do the same. The young apprentice won the Young Apprentice of the Year award from Newcastle City Learning in 2013.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice had a system of appraisal and development for all staff. The practice had good working arrangements with other healthcare professionals to share information.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice in-line with others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice had reviewed the needs of their local population and engaged with the NHS England and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and continuity of care, with urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a vision and strategy to deliver this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had a virtual patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population for example, a named GP for the over 75s and personal care plans. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice had good working arrangements with other healthcare professionals, such as district nurses, to share information to improve patient care.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Patients with long term conditions had a named clinical and administrative lead to co-ordinate their care. The practice were working towards improving their recall arrangements for patients with long term conditions. Longer appointments and home visits were available when needed.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. There were aspects of the practice which were good and related to all population groups. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice held bi-weekly baby clinics. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice offered extended opening hours. The practice was in the process of developing on-line services to include booking of appointments and ordering of repeat prescriptions.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register for patients with a learning disability. There were high numbers of ethnic minority groups registered with the practice. There was access to telephone and in person translation services and longer appointments were booked where needed. The practice website had the facility to translate its pages into several different languages. One of the GP partners spoke Czech. This attracted high numbers of Eastern European patients to the practice.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children and understood their responsibilities in relation to this.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice participated in the dementia screening enhanced service; they took bloods and had a screening tool to identify patients with dementia and co-ordinated access to local services for them.

For patients with poor metal health there was access to a counsellor, psychiatrist and drug and alcohol counsellor. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health. There were links to a local benefits advice worker and patients had a named lead clinician for their care.

Summary of findings

What people who use the service say

We spoke with seven patients on the day of our inspection. Most of the patients we spoke with were satisfied with the care provided by the practice and said their dignity and privacy was respected. Four of the patients said they had problems obtaining appointments. They said that they had to contact the practice by 8.30am or all the appointments available that day would be taken. Two of the four patients said they had problems obtaining appointments with the practice nurse.

We reviewed 14 CQC comment cards completed by patients prior to the inspection. Comments were positive. Common words used by patients included 'excellent', 'friendly', 'helpful' and 'considerate'.

The latest National GP Patient Survey completed in 2013/14 showed the large majority of patients were satisfied with the services the practice offered. All of the following results were above the National GP practice average across England. The results were:

- Percentage of patients who would recommend the practice – 89% (England average - 79.2%);
- Percentage of patients satisfied with phone access – 95% (England average – 77.7%);
- Percentage of patients reporting a good overall experience of making appointment – 84% (England average – 78%);

The practice carried out its own survey in February 2013. 75% of patients said they were happy with the appointments which were offered, 6% said they would like them advertised more throughout the practice. 96% of patients said they found obtaining an emergency appointment easy. There were questions asked in the survey regarding on-line services, 54% said they would like to be able to book appointments on-line with a GP and 61% would like to be able to order repeat prescriptions on-line. 64% said they would like text reminders for appointments.

Outstanding practice

- The practice were one of the first practices in the area to take on a young apprentice as a member of the administration staff. This was successful and started the process for other practices to do the same. The young apprentice won the Young Apprentice of the Year award from Newcastle City Learning in 2013.

Fenham Hall Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist.

Background to Fenham Hall Surgery

The area covered by Fenham Hall Surgery extends to the West of Newcastle Upon Tyne city centre to the A1, North to A167 and South to the North banks of the River Tyne.

The surgery is a converted former local authority clinic situated on a main road within a residential area of West Newcastle. It has seven patient consulting areas and administrative areas. There is disabled access to the building and a disabled toilet. There is parking in the surrounding area.

The practice has four GP partners and a salaried GP, four female and one male.

The practice provides services to approximately 8,000 patients of all ages. The practice is commissioned to provide services within a General Medical Services (GMS) Agreement with NHS England.

There are two practice nurses, a healthcare assistant and a practice manager, assistant practice manager with a range of reception and administration staff.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

The service for patients requiring urgent medical attention out of hours is provided by Northern Doctors Urgent Care Ltd and the 111 service.

Why we carried out this inspection

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

Detailed findings

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included the local Clinical Commissioning Group (CCG) and the NHS England.

We carried out an announced visit on 3 December 2014. During our visit we spoke with a range of staff. This included GPs, the practice manager, a healthcare assistant, reception and administrative staff. We also spoke with seven patients who used the service. We reviewed 14 CQC comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record

We looked at a range of information available about the practice as part of our Intelligence Monitoring. This included information from the Quality Outcomes Framework (QOF). The latest information available to us indicated there were no areas of concern in relation to patient safety.

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards reflected this.

We saw mechanisms were in place to report and record safety incidents, including concerns and near misses. The staff we spoke with demonstrated an understanding of their responsibilities and could describe their roles in the reporting process. Where concerns had arisen, they had been addressed in a timely manner. We saw outcomes and plans for improvement arising from complaints and incidents, including minor incidents, were discussed and recorded within staff meeting minutes. For example, staff had recorded four home visits for the incorrect day. This was discussed with staff and there was a refresh of staff training.

There were formal arrangements in place for obtaining patient feedback about safety. The practice had carried out an in-practice patient survey and had an active Patient Participation Group (PPG). The practice manager told us that any concerns raised would be used to inform action taken to improve patient safety. This showed the practice had managed safety consistently over time and so could demonstrate a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events and we were able to review these. The GPs told us that significant events were discussed as soon as practicable. They had daily informal meetings where they could discuss issues and there were also weekly clinical meetings on Tuesdays. If administration staff were involved in the event they could join the meeting and events were discussed. Staff could describe recent significant events and identify the learning they had taken from them. Records we saw confirmed this. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were disseminated by the practice manager to staff. Staff we spoke with were able to give examples of recent alerts. They told us alerts were discussed at clinical meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice were aware of which children were on the child protection register and those who gave “cause for concern”. The practice had a dedicated GP appointed as the lead for both safeguarding vulnerable adults and children. All of the GPs working in the practice been trained to level 3 for safeguarding children.

Practice training records showed that practice nurses and clinical staff were trained to level 2 for safeguarding children and administration staff had received training to level 1. The safeguarding lead GP had recently given an awareness session to staff on people trafficking. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had a chaperone policy. A notice was displayed in the patient waiting areas to inform patients of their right to request a chaperone. Staff we spoke with told us that normally a practice nurse or the practice manager, who was trained to do this, undertook this role. Staff who acted as chaperones were clear about the requirements of the role and had received disclosure and barring checks (DBS).

There were monthly safeguarding meetings which all GPs attended and the health visitor, the school nurse and midwife would attend where possible. We saw minutes of this logged on the practice shared information drive.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found all medicines were stored

securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure.

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

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. We saw an example of the process that was followed when a patient's medication had been changed following a visit to hospital. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

We saw printable prescriptions were held securely, however, the practice should review the storage and recording of blank FP10 prescriptions which are carried in doctor's bags in small quantities for home visits.

Cleanliness and infection control

We looked around the practice and saw it was clean, tidy and well maintained. We saw there were cleaning schedules in place and cleaning records were kept. The practice manager checked on a regular basis that these were followed. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice manager and one of the GP partners were the leads for infection control; they had both received infection control training. The lead practice nurse was to take over the infection control lead role in 2015 once she attended the infection control link practitioner course. The practice manager said that due to the shortage of practice nurses the practice had experienced it had not been possible for the practice nurse to be infection control lead.

We saw there was an up to date infection control policy and detailed guidance for staff about specific issues. All of the staff we spoke with about infection control said they knew how to access the practice's infection control policies. The practice were able to show us the last two infection control audits which were carried out yearly.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. The treatment room had walls and flooring that were impermeable, and easy to clean. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. The privacy curtains in the consultation rooms were disposable and replaced every six months. The practice had identified that the carpets in the GPs consulting rooms were not easy to wash and keep clean and these were to be replaced once the practice was refurbished.

We looked at some of the practice's clinical waste and sharps bins located in the consultation rooms. We saw arrangements were in place for the safe disposal of these items.

There was no requirement for the practice to have a legionella (bacteria found in the environment which can contaminate water systems in buildings) risk assessment due to there being no hot water system which stored water.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place.

Staffing and recruitment

We saw examples of staff files which showed that recruitment checks had been undertaken prior to employment. For example there was proof of identification, references and registration with the appropriate professional body. There was evidence of criminal records checks through the Disclosure and Barring Service (DBS) for clinical staff and GPs. However, the practice had a clear rationale as to why non clinical staff did not have DBS checks, however this is not documented in their recruitment policy or individual staff files, the practice manager said they would look at this.

The practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff which were needed to meet patients' needs. The

Are services safe?

deputy practice manager organised the rota for the administrative staff. The practice manager did weekly duty sheets to ensure there were enough clinical staff working and arranged locum cover if necessary for GPs.

The practice recognised that they had struggled to provide enough practice nurse sessions over recent months. Patients we spoke with told us that they had experienced difficulty in obtaining appointments with a practice nurse and some appointments had been rescheduled. The practice manager and lead GP explained how difficult it was to obtain locum practice nurse cover and that the healthcare assistant role was to be further developed to assist with work they could cover instead of the practice nurse.

Monitoring safety and responding to risk

The practice had systems and policies in place to manage and monitor risks to patients and staff. The practice manager told us they and the lead GP carried out a monthly walk around the building where they focussed on health and safety issues. These were picked up on a log which was maintained and reviewed. There had been a full health and safety risk assessment carried out in the practice by an external consulting company. We saw actions action had been taken to address the issues identified by this assessment.

The practice manager explained that they had good arrangements with local firms who carried out any maintenance work needed to the building and they felt the arrangements they had for the cleaning of the building worked well. The premises were safe and free from hazards. None of the patients we spoke to raised any concerns about health and safety.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff training records showed they had all received training in basic life support. Emergency equipment was available including access to oxygen and a defibrillator (used to attempt to restart a person's heart in an emergency). Staff we spoke with knew where this equipment was kept and confirmed they were trained to use it. They also showed us the emergency medicines which were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This had been updated regularly and contained relevant contact details for staff to refer to, for example who to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

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 found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as asthma, hypertension and diabetes. Patients with long term conditions had a named clinical and administrative lead to allow the practice to focus on specific conditions. There were regular clinics where people were booked in for recall appointments.

We saw that diabetes had been an area where the practice thought it could improve and an audit of this area had been carried out. This resulted in the identification of further patients who required treatment. A second audit demonstrated that there was an improvement in 87.5% (63 patients out of 72) of the patient's condition.

There was a pathway of care for frail and elderly patients. They all had a named GP. The practice had a close working relationship with local nursing homes.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2013 / 2014. The QOF is part of the General Medical Services (GMS) contract for general practices. Practices are rewarded for the provision of quality care. We saw the practice had scored well on clinical indicators within the QOF. They achieved 98.39%, which was above the average in England of 96.44%.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us four clinical audits that had been undertaken in the last year. All of them were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example there had been an audit on the usage and reduction of a medicine used to reduce insomnia involving 66 patients. This had resulted in 31 being successfully changed to a safer alternative medication (this medication is easier to reduce and has less side effects) and 12 patients ceased to take the original medicine.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around audit and quality improvement. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff had received annual training such as basic life support, fire and safeguarding training. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list.

Are services effective?

(for example, treatment is effective)

All staff undertook annual appraisals which identified learning needs from which training plans were documented, these were reviewed six monthly. Staff told us that the practice was proactive in providing additional training where necessary. For example staff had attended training regarding dealing with challenging situations.

The practice manager provided us with comprehensive records of staff training. Each member of staff had an annual training record setting out when basic training had been carried out and when it was due for renewal and also when their annual appraisal was due. There were records of the training which clinical staff had attended at time out sessions including sessions on for example, chaperone training, constipation and irritable bowel syndrome. There was also a forward training plan which set out which basic training courses were booked in the future so that staff could arrange to carry out refresher training. There was a separate training plan for the practice manager to monitor safeguarding children training which easily identified which level of training staff had received and when.

The practice were one of the first practices in the area to take on a young apprentice as a member of the administration staff. This was successful and started the process for other practices to do the same. The young apprentice won the Young Apprentice of the Year award from Newcastle City Learning in 2013.

Working with colleagues and other services

The practice had good working arrangements with other health and social care providers, to co-ordinate care and meet people's needs. We saw meetings were arranged to discuss those patients at high risk or living in vulnerable circumstances. The multidisciplinary team included community nurses, school nurse, midwife, pharmacist, social work and health visitor's teams, who would attend along with Marie Curie and Macmillan nurses. The practice worked closely with a local service for the treatment of drugs and alcohol abuse.

Staff told us they engaged in regular meetings with other practice staff from across the locality to discuss issues and share good practice. Staff met with the local mental health team on two different levels, with the counsellors and Primary Mental Health Care Worker.

Correspondence from other services such as test results and letters from hospitals were received either electronically or via the post. All correspondence was scanned and passed to the patient's referring GP and the duty doctor. We saw the practice computer system was used effectively to log and progress any necessary actions.

Information sharing

The practice had systems in place to provide staff with the information they needed to carry out their roles and responsibilities. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider which was Northern Doctors Urgent Care Ltd. This enabled patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals using the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

There was a protocol in place to review emails from the out of hours provider and also for hospital discharge information.

Consent to care and treatment

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. Staff we spoke with told us they ensured they obtained patients' consent to treatment. Staff were able to give examples of how they obtained verbal or implied consent. We also saw a consent to treatment form which the practice used for consent to investigations or specific treatment.

GPs we spoke with showed they were knowledgeable of Gillick competency assessments of children and young people. Gillick competence is a term 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.

Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the Mental Capacity Act (MCA). We found the GPs were aware of the

Are services effective?

(for example, treatment is effective)

MCA and used it appropriately. The GPs described the procedures they would follow where people lacked capacity to make an informed decision about their treatment. They gave us some examples where patients did not have capacity to consent. The GPs told us an assessment of the person's capacity would be carried out first. If the person was assessed as lacking capacity then a "best interest" discussion needed to be held. They knew these discussions needed to include people who knew and understood the patient, or had legal powers to act on their behalf.

Health promotion and prevention

It was practice policy to offer all new patients a health check with a practice nurse. New patients were able to download a pre-registration form and a medical questionnaire from the practice website which, once completed, they could submit electronically, post or hand into the reception team. The practice nurse or healthcare assistant carried out assessments of new patients that covered a range of areas, including past medical history and ongoing medical problems.

Carers known to the practice were coded on the practice system so they could be identified. The practice were able to refer them to the local carers centre and also social services where appropriate.

The practice offered a full range of clinics; these included counselling, minor surgery, contraceptive services, smoking cessation and management of long term conditions. There was information on the practice website regarding travel and flu vaccination requirements.

The practice offered baby and anti-natal clinics. Nationally reported data for 2013/14 showed the practice offered child development checks at intervals that were consistent with national guidelines. They offered routine immunisations for babies and children under five, during clinic appointments.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice regarding patient satisfaction. This included information from the national GP patient survey. The data showed that the proportion of patients who described their overall experience of the GP surgery as good or very good was 94%, the England average being 85%. The proportion of patients who said their GP was good or very good at treating them with care and concern was 93%, the England average was 85%. Patients who said the practice nurses were good at treating them with care and concern was 97%, the England average was 90%.

We reviewed 14 CQC comment cards completed by patients prior to the inspection. Comments were positive. Common words used by patients included 'excellent', 'friendly', 'helpful' and 'considerate'.

We spoke with seven patients on the day of our inspection. Most of the patients we spoke with were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff were aware of the need to keep records secure. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation. Information regarding patient confidentiality was in the practice information leaflet.

The practice had policies in place to ensure patients and other people were protected from disrespectful, discriminatory or abusive behaviour. The staff we spoke with were able to describe how they put this into practice.

Care planning and involvement in decisions about care and treatment

Patients told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given.

From the 2014 National GP Patient Survey, 94% of patients said the GP they visited had been 'good' at involving them in decisions about their care (England average was 81%).

We asked staff how they made sure that people who did not have English as a first language were kept informed about their treatment. Staff told us they had access to an interpretation service, either in person or by telephone.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our visit told us staff responded compassionately when they needed help and provided support when required. We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups.

Notices in the patient waiting room and patient website also told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

There was a palliative care register and regular contact with the district nurses. There were monthly palliative care meetings which involved GPs, district nurses and MacMillan nurses.

Staff told us that if families had suffered bereavement, this was followed up by the practice, with either a visit or telephone call depending upon the circumstances.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the practice PPG. The group had suggested that signage outside of the surgery could be improved and action was taken to improve this.

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of older patients and those with long-term conditions. Those aged 75 and over had a named GP and personal care plans. There were named clinical leads for patients with long term conditions. The practice were working towards improving their recall arrangements for patients with long term conditions.

The practice had begun to carry out further work with a young people's group to gain their views on the practice. They also attended the local secondary school during the school year and worked with pupils. The practice offered bi-weekly baby clinics.

Services had been planned to meet the needs of the working age population, including those that had recently retired and those at school or college. Of those respondents to the 2014 National GP Patient Survey of the practice: 87% said they were satisfied with the practice's opening times. There were extended opening hours on Tuesday evenings and Saturday mornings.

Residents from a local bail hostel were registered with the practice. There were different arrangements in place for the residents, for example arrangements for the collection of prescriptions. The practice held regular meetings with key workers from the bail hostel to ensure their needs were met.

The practice had a named lead for patients with learning disabilities and held a learning disabilities register.

The practice participated in the dementia screening enhanced service; they took bloods and had a screening tool to identify patients with dementia and co-ordinated access to local services for them.

For patients with poor metal health there was access to a counsellor, psychiatrist and drug and alcohol counsellor. There were links to a local benefits advice worker and patients had a named lead clinician for their care.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. There were high numbers of ethnic minority groups registered with the practice. There was access to telephone and in person translation services and longer appointments were booked where needed. The practice website had the facility to translate its pages into several different languages. One of the GP partners spoke Czech. This attracted high numbers of Eastern European patients to the practice.

All patient areas were on the ground floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. There was a loop system available to assist patients who were hard of hearing.

Access to the service

Appointments were available from 8:30am to 6:00pm Mondays and Friday with a late evening on Tuesdays 6:30pm to 8:15pm by appointment. There were extended hours on a Saturday morning by appointment only from 8:15am to 10:15am.

Appointments could be booked up to six weeks in advance. Two thirds of the appointments on any given day were pre bookable and the other third released on the day. The appointments available on the day which were for emergencies were released at 8:30am when the practice opened and then further appointments released at lunchtime.

Comprehensive information was available to patients about appointments on the practice website and in the patient information leaflet. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message

Are services responsive to people's needs?

(for example, to feedback?)

gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The practice were currently in the process of making arrangements to offer on line appointments.

Longer appointments were also available for patients who needed them and for those with long-term conditions and patients who needed an interpreter. This also included appointments with a named GP or practice nurse.

Four out of seven patients we spoke with during our visit to the practice said they had problems obtaining emergency appointments. They said that they had to contact the practice by 8.30am or all the appointments available that day would be taken. Two of the seven the patients we spoke with said they had problems obtaining appointments with the practice nurse. One of the CQC comment cards which were completed made reference to it sometimes being difficult to get through on the telephone. However information from the GP Patient Survey showed that the large majority of patients were satisfied with making appointments, 84% of patients reported good overall experience of making an appointment, this is higher than the England average which is 78%. The survey also asked patients how easy it was to get through to someone at the surgery on the phone and 89% gave a positive answer, the England average being 75%.

The practice had carried out its own survey of patients in February 2014 and had asked patients how easy they found making an appointment with a GP when they needed to be seen urgently and 69% said they found it easy. The practice action plan in response to this was to monitor the situation and then re-assess.

We spoke with reception staff about making appointments and looked at what appointments were available in the coming weeks. Routine appointments were available in the following week for both the GPs and the practice nurses and there were still available appointments for emergencies on the day of our inspection. Reception staff told us that patients did not need to contact them by telephone at 8:30am on the day to obtain an emergency appointment these could be obtained during the morning or later that day when other appointments were released.

We spoke with the practice manager and lead GP about the issue of emergency, on the day, appointments and gave them the feedback we had received from patients which they said they would take away and look at as this issue had not been raised with them before our inspection. The issue of the shortage of practice nurse appointments was discussed. The practice were trying to cover some nurse sessions due to the absence of a practice nurse and were aware of the problems in this area.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. Information regarding how to make a complaint was included in the patient information leaflet. One patient we spoke with said they had made a complaint and it had been dealt with to their satisfaction.

The practice manager supplied us with a schedule of eight complaints which had been received in the last 12 months and we found these had all been dealt with in a satisfactory manner. The practice also had a log of eight compliments which they had received in the last year.

One of the GP partners who was the lead for quality reviewed the complaints quarterly with the practice manager to detect any themes or trends.

Are services well-led?

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. Staff were committed to achieving the best possible outcomes for patients and this was demonstrated by the practice's QOF performance. The practice's patient's charter provided a clear outline of how it would deliver its overall aims and objective and also what their responsibilities and expectations were. There was protected time for the GP partners and practice manager to hold an annual planning meeting to assess the delivery of the service.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. For example age discrimination, recruitment and safeguarding policies. They had all been reviewed annually and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above national standards.

The practice had ongoing clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice had arrangements in place for identifying, recording and managing risks. Risk assessments such as a health and safety risk assessment had been produced and implemented. The practice manager held weekly governance meetings with the GP partners at which risks were discussed.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles including non-clinical area. For example, there was a lead GP for safeguarding, shared care, quality and mental health. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

There were weekly clinical and practice nurse meetings. Staff told us that they had the opportunity to raise issues with the management at the practice and the practice manager and clinicians had an open door policy so that staff could speak with them where necessary. The practice manager told us it was difficult to hold team meetings for administration staff, these were held occasionally and we saw minutes of these. The practice manager explained that most of the communication to administration staff was via email or the practice's software management system. Full team meetings were to be implemented in the near future. The practice manager was responsible for human resource policies and procedures.

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

The practice had gathered feedback from patients through patient surveys, suggestion box, compliments and complaints received. We looked at the latest patient survey which was based on the areas which the PPG members wanted the survey to focus on. This was in relation to communication with patients and the services patients would like them to provide. Following the survey an action plan was drawn up to review current systems of communication. Results of the survey were available on the practice website.

The practice PPG had met regularly until early 2014 when membership decreased and the group was no longer representative of the practice population. It was decided to then have a virtual group and correspond with members by email and letter. Patients were given the opportunity to join via the messages on the screen in the waiting area, via the practice website and by the practice information leaflet and newsletter. The group consisted of males and females with an age range between 19 and 70 and included patients from differing ethnic groups.

We saw the practice had a quarterly newsletter. The latest newsletter gave updates on staff training dates, opening hours, repeat prescriptions and the location of the local walk in centres.

The practice had a whistleblowing policy which was available to all staff and staff confirmed they were aware of this.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. They said these provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate

Are services well-led?

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

to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw staff were supported to develop through regular training, supervision and appraisal. Staff told us that the practice was very supportive of their training needs.

We saw practice staff met on a regular basis. Staff from the practice also attended the Clinical Commissioning Group (CCG) protected learning time (PLT) initiatives. This provided staff with dedicated time for learning and development. There was also in house protected learning time.