The James Street Family 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

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Overall summary

Letter from the Chief Inspector of General Practice

The James Street Family Practice offers a range of primary medical services from their surgery at 49, James Street, Louth.

We carried out an announced inspection on 21 October 2014 as part of our new comprehensive inspection programme.

During the inspection we spoke with patients that used the practice and met with a member of the patient participation (PPG). A PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care. We also reviewed comments cards that had been provided by CQC on which patients could record their views.

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

Our key findings were as follows:

- The practice had systems in place to manage and review risks to vulnerable children, young people and adults. Staff were knowledgeable and we saw examples where risks to children had been identified and appropriate referrals and follow ups had taken place.
- The practice was committed to monitoring and improving outcomes for patients and had an effective and proactive system in place to support patients with end of life care. Continuity of care was maintained for end of life patients by having two named GPs.
- Patients we spoke with and comments we reviewed reflected that they received an excellent service and praised staff, describing them as compassionate, efficient, helpful and caring. They said staff treated them with dignity and respect.

Summary of findings

- The practice operated a responsive appointment system called 'Dr First'. Patients were able to choose which GP they wanted to speak to and would receive a call back from the GP who assessed and prioritised patients' needs and appropriate appointment length.
- There was clear leadership with all staff being aware of their role and responsibilities. There was a strong team ethos and staff felt well supported and valued.

We saw areas of outstanding practice including:

- The practice was proactive in taking part in delivering a programme of sexual health education in local schools.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely 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 providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice had carried out appraisals and personal development plans for staff. Staff worked well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to 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 held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. 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 and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and had appointment slots reserved for older people.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Processes were in place and referrals made for patients in this group that had a sudden deterioration in health. Appointment times were tailored to individual needs and home visits were available when required. Structured annual reviews to check their health and medication needs were being undertaken. All patients identified as being at risk of an unplanned admission hospital had a named GP and a care plan in place.

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 who were at risk. The practice held a register of looked after children. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and schools and the practice were proactive in taking part in delivering a programme of sexual health education in local schools. The practice co-ordinated babies eight week check up appointment with their appointment for their first immunisations in order to save the parents making two separate appointments and to ensure that immunisations took place.

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

Summary of findings

been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people living in vulnerable circumstances. The practice registered patients who were resident at a local hostel for the homeless.

The practice did not carry out annual health checks for people with learning disabilities as these took place at the local hospital. However they held a register of patients with learning disabilities and supported them with physical health needs. Appointment length was tailored to individual needs and carers were also supported including by means of different carer support groups.

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. Staff showed excellent awareness of their responsibilities regarding raising and documenting safeguarding concerns and how to contact relevant agencies in and out of hours.

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). Patients experiencing poor mental health received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia and had a dementia carers support group.

The practice told us they had systems in place to monitor repeat prescribing for people receiving medication for mental ill-health and the steps they would take to support a patient experiencing a mental health crisis. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

The James Street Family Practice had carried out a patient survey of 59 patients between October 2013 to January 2014. 95% of patients who responded said they were satisfied with the time and management the GP gave to their illness. Results from the national GP NHS patient survey regarding the practice, showed that 80% of respondents said the last GP they saw or spoke to was good at listening to them. The national survey also reflected that 75% of patients would recommend the practice to others. This figure was higher than the average for practices in the CCG.

Patients we spoke with on the day of our visit were all very positive about the care and support they received at the practice.

We received 36 comment cards on the day of our inspection. Most of the comments were positive. Patients felt well looked after and described staff as compassionate, caring and supportive. We met with a member of the patient participation group (PPG). The PPG is a group of patients who highlight patient concerns and needs and work with the practice to drive improvement within the service. The PPG member told us they had worked with the practice to address issues raised by patients.

Outstanding practice

The practice was proactive in taking part in delivering a programme of sexual health education in local schools.

The James Street Family Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and the team included a GP and a GP practice manager.

Background to The James Street Family Practice

The James Street Family Practice is a GP practice which provides a range of primary medical services to around 8,400 patients from a surgery in the market town of Louth in Lincolnshire. Their services are commissioned by Lincolnshire East Clinical Commissioning Group (CCG). The service is provided by three full time male GP partners, one part time female GP partner, one managing partner, one independent nurse prescriber, one minor illness nurse, two practice nurses and two health care assistants. They are supported by a management team, reception and administration staff.

Local community health teams support the GPs in provision of maternity and health visitor services.

The practice has one location registered with the Care Quality Commission (CQC). This is at 49 James Street, Louth, Lincolnshire. LN11 0JN.

The surgery is in a modern two storey building with a large car park which includes car parking space designated for use by people with a disability near the surgery entrance.

We reviewed information from Lincolnshire East clinical commissioning group (CCG) and Public Health England which showed that the practice population had similar deprivation levels to other practices within the CCG and the average for practices in England.

The practice has opted out of the requirement to provide GP consultations when the surgery is closed. The out-of-hours service is provided by Lincolnshire Community Health Services NHS Trust.

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

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

Detailed findings

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We also reviewed information we had requested from the practice prior to our visit, as well as information from the public domain including the practice website and NHS choices.

We carried out an announced visit on 21 October 2014. During and subsequent to our visit we spoke with a range of staff including GPs, the management team, a nurse practitioner, nurses, a healthcare assistant, reception and administration staff. We also spoke with patients who used the service. We talked with carers and family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

During our visit we spoke with a representative of the patient participation group to gain their views on the service provided by the practice.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These were, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 3 years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last three years and we were able to review these. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms which were available on the practice computer system and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. For example one member of staff we spoke with described an incident which had been reported when the vaccine refrigerator was found to be above the recommended temperature range. They told us how as a result they had learnt that it was important to check the temperatures twice a day and we saw that procedures had been changed to implement this.

One of the partner GPs had responsibility for dealing with MHRA alerts and presented findings to relevant staff at a quarterly meeting. We saw records of these meetings which included conclusions and actions required.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had been trained to an appropriate level in safeguarding to enable them to fulfil this role. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern..

GPs were appropriately using the required codes on their electronic case management system to ensure risks to vulnerable people, children and young people who were looked after or on child protection plans were clearly flagged. The lead safeguarding GPs were aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services. We saw examples of one of the GP's involvement in a child safeguarding conference and also of how a child had been identified as being at risk and referred appropriately. We saw that the practice had a recall policy in place and if children persistently failed to attend appointments for example for childhood immunisations this would be followed up with a telephone call by a nurse.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All nursing staff, including health care assistants, had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, all staff had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

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

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

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

We were told that the GP with responsibility for the dispensary held regular prescribing meetings and reviewed prescribing data and national guidance and changes were implemented accordingly.

The nurses administered vaccines and we saw evidence that they had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were signed by all dispensing staff and being followed. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held separately and securely in a key safe. There were arrangements in place for the destruction of controlled drugs.

Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed and records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked annually.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles.

There were also contracts in place for the collection of general and clinical waste. We saw that waste was stored securely prior to collection by the contractor.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Good

Are services safe?

The practice had a policy for the management, testing and investigation of legionella. Legionella can be transmitted to people via the inhalation of mist droplets which contain the bacteria. The most common sources are water tanks, hot water systems, fountains and showers.

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. We saw evidence of calibration of relevant equipment; for example weighing scales and the spirometer.

Staffing and recruitment

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

The practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the findings of the infection control audit had been shared with the team.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, one of the GP partners described the system they had in place to monitor repeat prescribing for people receiving medication for mental ill-health and the steps they would take to support a patient experiencing a mental health crisis.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available and staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable 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. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. One of the GP partners told us how they had successfully implemented the plan during severe flooding when the whole premises had been evacuated.

Good

Are services safe?

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.

Good

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 approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence 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 required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as asthma, cancer, diabetes and stroke and were supported by named practice nurses or healthcare assistants in this work. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

We were shown the process the practice used to review patients recently discharged from hospital. The practice had a discharge summary protocol in place which required summaries to be reviewed within three days of receipt and all discharges were actively reviewed by advanced nurse practitioners and dealt with accordingly including arranging follow ups. Patients were contacted to advise them of any actions required.

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 to support the practice to carry out clinical audits.

The practice showed us eight clinical audits that had been undertaken. One of the audits we looked at was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. The practice had audited their patients' attendance at Accident and Emergency (A & E) department from 2012. One of their findings was that there was a high number of children attending in the evenings. As a result they implemented early evening appointments for children at the practice and had previously placed one of their own GPs in A & E to try and reduce attendances. This resulted in a reduction in A & E attendances from 2012 to 2013.

The GPs told us clinical audits were often linked to medicines management information. For example, we saw three audits relating to prescribing of certain drugs. Following the audits, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. QOF is a system used to monitor the quality of

services in GP practices. QOF consisted of groups of indicators against which practices score points according to their level of achievement. The practice had performed above the CCG and national average in QOF and met all the minimum standards for QOF in diabetes, asthma, chronic obstructive pulmonary disease (lung disease) and relating to mental health. This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved.

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. There was also a system in place to check 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 provided had an effective system in place to support patients with end of life care. It had a palliative care register of 170 patients and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. All patients on the list were identified on their electronic patient record and had a care plan in place. Patients had a first and

Good

Are services effective?

(for example, treatment is effective)

second named GP, this meant if their primary GP was not available there would still be continuity of care. There was a board in the reception area identifying end of life patients and their needs. This assisted the reception team to support the patient appropriately when they contacted the practice.

The practice was piloting the electronic Palliative Care Co-ordination Systems (EPaCCS). This system enabled the immediate recording and sharing of people's care preferences and key details about their care at the end of life for example with district nurses and the local hospice. When a patient died the GP contacted the family to discuss the care the patient had received.

The practice also had a register of patients they had identified as being at a higher risk of unplanned admissions including older people and those with long term conditions. These patients had care plans in place and a named GP.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors and nursing staff. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and compression bandaging. Those with extended roles such as seeing patients with minor illness, long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received test results, X ray results and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a discharge summary protocol in place. The GP or advanced nurse practitioner who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Staff we spoke with said that they had a close and effective working relationship with other members of the multi-disciplinary team, for example, district nurses, health visitors and the local hospice. These relationships between the teams ensured that the patient's experience was streamlined by effective communication and individual care planning.

The practice was commissioned for various enhanced services. These services are agreed by the clinical commission group (CCG) in response to local needs and priorities, sometimes adopting national service specifications, for example, the extension of practice opening hours. One of the enhanced services provided by the practice related to dementia care and the practice had a robust process in place to follow up dementia patients discharged from hospital.

The practice held regular multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by practice clinical staff, district nurses, palliative care nurses and the local hospice. Decisions about care planning were documented.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system

Good

Are services effective?

(for example, treatment is effective)

enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff and patients told us this system worked well.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record SystmOne to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example in the last 12 months they had implemented a policy about making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. There were also systems in place to involve an Independent Mental Capacity Advocate (IMCA) to support decision making for a patient where appropriate.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing, with the support of a carer where appropriate. We saw an example of a care plan for a patient with dementia and noted that consent for care had been discussed with the patient. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. One of the GPs told us clinicians attended best interest meetings when required. The practice had a protocol in place relating to Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). Clinical staff demonstrated a clear understanding of this.

Health promotion and prevention

The practice offered NHS Health Checks to all its patients aged 40-74. Practice data showed that for the year 2013-2014 62% of patients in this age group who were invited took up the offer of the health check. The practice manager told us they had invited further patients beyond their target number to attend for a health check.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. The practice kept a register of all patients with a learning disability and supported them with physical health requirements. They did not offer an annual physical health check as this service was provided at the local hospital.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was below average for the CCG, but data we looked at during our inspection showed that for the year to date they had performed above the CCG average. There was again a clear policy for following up non-attenders by a practice nurse. The practice's performance for flu vaccinations for over 65's was above the CCG average but was below average for under 65's and those classed as at risk. The practice had a system for flagging patients who were eligible for vaccinations such as those for the prevention of shingles and opportunistically booked them in for the vaccination if possible when they contacted the practice on another matter.

The practice co-ordinated babies eight week check up appointment with their appointment for their first immunisations in order to save the parents making two separate appointments and to ensure that immunisations took place.

The practice was able to signpost to other services such as referring young people to sexual health clinics locally. The practice were proactive in taking part in delivering a programme of sexual health education in local schools. The practice also hosted a weekly smoking cessation clinic to support patients who wished to stop smoking.

We looked at examples of advanced care plans which the practice had in place for patients with long term conditions such as diabetes and saw that this group of patients received a structured annual review.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 59 patients undertaken by the practice's patient participation group (PPG). The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed that 88% of patients rated their overall experience at the surgery as good. The practice was just below the CCG average for its satisfaction scores on consultations with doctors and nurses with 80% of practice respondents saying the GP was good at listening to them and 82% saying the GP gave them enough time. The practice's own survey showed that 95% of patients said they were satisfied with the time and management the GP gave to their illness.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 36 completed cards and the majority were very positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three comments were less positive in respect of preferring to making a face to face appointment initially rather than the GP calling the patient back. We also spoke with five patients on the day of our inspection. All told us they 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. Disposable 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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. There was a system in place to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 69% of practice respondents said the GP involved them in care decisions and 75% felt the GP was good at explaining treatment and results. Both these results were below average compared to the CCG area.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. We spoke with a parent who had brought their child for an appointment and they were very positive about the way their children had been involved in consultations with the GP. Another patient we spoke with who suffered with a long term condition described how they had been involved in agreeing their care plan.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with and comment cards we reviewed were positive about the emotional support provided by the practice. For example, they described staff as being supportive and compassionate when they needed help.

Notices in the patient waiting room, on the TV screen and patient website also told people how to access a number of support groups and organisations. The practice's computer

Good

Are services caring?

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.

Staff told us that if families had suffered a bereavement, their usual GP contacted them and either visited them or offered a patient consultation at a flexible time and location to meet the family's needs and gave them advice on how to find a support service. One patient we spoke with told us they were aware of a patient who had had a bereavement. The patient had shared with them how touched they had been by the level of support they had received from the practice which had included receiving a condolence card.

Good

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 in the way services were delivered.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example we spoke with the chair of the PPG who told us they had been involved in making changes to the appointment system and they felt their ideas had been listened to and acted upon.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training.

If patients were on long-term sick leave this was identified on their notes to enable the GPs to support them to return to work.

Clinical areas to which patients required access were situated on the ground floor of the building. There were wide corridors which made movement around the practice easier and helped to maintain patients' independence. 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. The premises and services had been adapted to meet the needs of people with disabilities. There was a hearing loop installed.

The practice had a population of primarily English speaking patients though it could cater for other different languages through translation services. Patients had individual needs highlighted on the front page of their records so for example if a patient had a sight impairment instead of just the visual information on a screen in the waiting room which told patients to go in to see the GP, the GP would know to go out to the waiting room to call the patient in.

One of the GP partners told us they had homeless patients who were registered at a local hostel for the homeless.

Access to the service

Appointments were available from 8am to 630pm on weekdays. The practice was closed between 1pm and 2.30pm on Wednesday afternoons for staff training.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. 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 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 operating an appointment system called 'Dr First'. This was operated by means of patients speaking to a receptionist who would take contact details and which GP the patient would like to see. The GP would call back in order to assess and prioritise patients and identify the appropriate appointment length. One of the GPs told us using this system also meant that patients could see the GP of their choice thereby improving continuity of care. This also meant that some problems could be dealt with over the phone. GPs booked follow up appointments if required, while the patient was still in the surgery.

Home visits could be arranged for those unable to attend the surgery, either because they were too ill or housebound. This was of particular benefit to older patients and those with long-term conditions. A GP was responsible for each nursing home in the area and attended as required.

Telephone consultations and appointments could also be booked online which was particularly useful for patients with work commitments. Appointments were available outside of school hours for children and young people.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another

Good

Are services responsive to people's needs?

(for example, to feedback?)

doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment were able to make appointments on the same day of contacting the practice. One patient we spoke with told us how they had booked their appointment two weeks in advance and how convenient they found this. They also commented that it was easy to see a GP on the same day when required. Three patients commented that they would prefer to ring and make a face to face appointment rather than waiting for a GP to call them back.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system both in the waiting room and on the practice website. Reception staff we spoke with told us that if a patient wanted to make a complaint they would also give them information on advocacy support to do so. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at a sample of complaints received in the last 12 months and found they had been handled satisfactorily and in a timely way.

The practice had reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. We also saw an annual summary of complaints which identified lessons learnt, outcomes and who was responsible for actions required.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The lead GP described how the practice vision and values was to work with the local community to make a difference by providing the highest quality medical services in an honest, supportive environment that is realistic, sustainable and rewarding in order to be a practice that cares for patients, staff, as well as the local community. The members of staff we spoke with all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We looked at 12 of these policies and procedures. All the policies and procedures we looked at had been reviewed annually and were up to date. New employees were required to read relevant policies as part of their induction.

There was a clear leadership structure with a well identified management team in place with named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the partner GPs was the lead for safeguarding. Each partner had clear responsibilities and was also responsible for a range of clinical areas and enhanced services.

The members of staff we spoke with 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.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example we looked at an audit which related to prescribing and as a result of the audit patients had been reviewed and medication altered.

The practice had arrangements for identifying, recording and managing risks. We saw that risk assessments had been carried out. Where risks had been identified an action plan had been produced . For example we saw evidence of discussions as a result of learning from the last fire evacuation. The practice held regular governance meetings.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice had a number of policies in place to support staff such as those relating to induction, sickness reporting and accident reporting. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, suggestions, compliments and complaints received. We looked at the results of the annual patient survey and these showed that some patients were dissatisfied with the practice opening hours. As a result of this part of the practice's action plan was to research whether extended hours was a viable option for the practice and were introducing a pilot of extended hours with pre bookable Saturday morning appointments planned for early 2015.

The practice had an active patient participation group (PPG) as well as a patient reference group (PRG) which was a virtual group who also responded to practice surveys and helped with two-way communication on ideas about how to improve services and understand patient priorities and issues. The PRG included representatives from various population groups. The PPG had been involved with the annual patient survey and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that whenever they asked for further training to extend their role it always happened. Staff told us they felt very involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a monthly 'extra mile award'. Staff

Are services well-led?

Good

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

nominated another colleague for something they had done at work that month which was over and above the requirements of their role. Staff told us this made them feel valued.

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of actions to take if they had a concern and knew how to access policies.

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 five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

A senior partner of the practice worked with the General Medical Council and the NHS local area team to support and tutor under performing GPs from other surgeries.

The practice had completed reviews of significant events and other incidents and shared with staff at specific meetings to ensure the practice improved outcomes for patients.