St James Surgery

Quality Report

89 Wash Lane, Clacton-on-Sea,
Essex. CO15 1DA
Tel: 01255 222121
Website: www.stjamesandstosythsurgery.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St James Surgery on 18 October 2016. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- Staff were aware of their responsibilities regarding safety, and reporting and recording of significant events. There were policies and procedures in place to support this.
- The practice assessed risks to patients and staff. There were systems in place to manage these risks.
- Processes and systems around medicines management kept patients safe.
- Staff used current guidelines and best practice to inform the care and treatment they provided to patients.
- All patients said that they were treated with dignity and respect and involved in decisions about their care and treatment.
- There was a clear and effective complaints system in place. Any comments regarding suggestions for improvements using this system were also responded to by the practice.
- Patients told us that access to appointments was good. The practice had a system in place to try to provide continuity of care.
- The practice was equipped to meet the needs of its patient population.
- There was a strong leadership structure in place and staff were invested in and supported to increase their knowledge and skills.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw one area of outstanding practice:

- Where staff showed an interest in a particular clinical area, the practice supported that member of staff to gain knowledge and skill in that area. If they were unable to drive to the location the practice financially supported them to physically access the training and paid staff overtime if training took place outside of their working hours.

Summary of findings

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 were aware of and could explain their role and responsibilities in reporting and recording of significant events. They told us, and we found evidence to show, that following investigation of any incidents the outcome was shared with appropriate staff to ensure that lessons were learned and action was taken to improve safety in this area in the future.
- When things went wrong involving patients, appropriate actions were taken and a full investigation completed, with the person affected, or their designated next of kin, given accurate and honest information.
- There were processes and policies in place for the safe management of medicines.
- There were clear safeguarding processes in place for adults and children. Staff were aware of their roles and responsibilities with regards to safeguarding and were aware of potential signs of abuse.
- There were systems in place for the identification and assessment of potential risks to patients, staff and the premises, and plans in place to minimise these.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff had access to the latest clinical guidelines and best practice guidance and used these to assess and deliver patient care.
- Clinical staff used a range of measures to ensure they had the skills, knowledge and experience to provide effective care.
- We found all staff had received an appraisal and had a personal development plan.
- The practice completed audits which were relevant to the service and demonstrated quality improvement.
- Staff had opportunities for career progression and ongoing learning.
- The practice had good working relationships with other health and social care staff.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- The majority of patients told us that they were treated with dignity and respect by staff, involved in their treatment and that staff were good.
- We saw staff treated patients with kindness and respect.
- The practice had identified and supported a good percentage of carers on their register.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The latest GP survey, published in July 2016, showed the practice was rated higher than the CCG and national average with regards to satisfaction with opening hours and making an appointment generally.
- Patients told us that access to appointments was good. The practice had a system in place to try to provide continuity of care.
- The practice was equipped to meet the needs of its patient population.
- There was a complaints, compliments and comments leaflet in the waiting area with a box to put them in. The practice responded to these in a timely manner.

Are services well-led?

Good

The practice is rated as good for being well-led.

- There was a clear leadership structure in place with strong governance systems.
- The practice had policies and procedures in place, which were relevant to the practice, regularly reviewed and updated as required.
- There were systems in place for notifying about safety incidents and evidence showed that the practice complied with the duty of candour when investigating and reporting on these incidents.
- The practice sought feedback from staff and patients, which it acted on. There was a virtual patient participation group which provided a 'critical friend' view and a balanced viewpoint on the various aspects of the service provided.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

- If patients required a longer appointment due to complex needs or multiple medical conditions this was available.
- All older patients had a named GP.
- Those patients unable to come to the practice, for example, due to being housebound, were able to access home visits, vaccination and health checks from the GP and nursing staff.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Both GPs and nursing staff took the lead in reviews and management of patients with long term conditions.
- The practice performance for diabetes indicators was in line with or higher than the CCG and national averages. For example, the number of patients who had received a foot examination and risk classification was higher than the CCG and national average.
- All patients had a named GP.
- Those patients unable to come to the practice, for example, due to being housebound, were able to access home visits, vaccination and health checks from the GP and nursing staff.
- The practice worked with other health and social care professionals to provide coordinated care and treatment.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems and processes in place to enable staff to identify and take appropriate action to monitor and safeguard children and young people living in disadvantaged situations. For example, where a child did not attend a booked appointment this was followed up.
- The GP practice completed the pre-school checks.
- Urgent same day appointments were available for babies and children.
- Immunisation rates were above CCG and national averages for all standard childhood immunisations.
- Appointments were available outside of school hours.

Summary of findings

- The premises were suitable for children and babies.

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 practice offered Saturday morning pre booked appointments. These appointments could be used for a variety of reasons including travel vaccines and chronic disease management.
- Prescriptions were sent electronically to the patients preferred chemist.
- The practice offered online appointment booking and prescription requests.
- The percentage of women aged 25-64 who have had a cervical screening test in the past 5 years was above the CCG and national average.
- The practice operated a virtual patient population group (PPG) which was popular with this group.

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 was aware of those patients on their register who lived in vulnerable circumstances.
- The practice computer system provided an alert to staff if patients had any sensory deficit and therefore may require extra support to access their appointment.
- If patients required a longer appointment due to complex needs or multiple medical conditions this was available.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- All patients had a named GP.
- The practice sign-posted vulnerable patients to various support groups and voluntary organisations.
- There were established systems and processes in place to ensure patient safety and enable staff to identify and take appropriate action to safeguard patients from abuse. Staff knew how to recognise signs of abuse in vulnerable adults and children.
- The practice had identified and supported carers on their register.

Summary of findings

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 performance for mental health indicators was higher than the CCG and national average. For example, the percentage of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, was higher than the CCG and national average.
- The practice worked closely with mental health professionals to deliver coordinated care in the community.
- Longer appointments were available for patients experiencing poor mental health.
- The practice sign-posted patients to local voluntary support services.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing mostly above local and national averages. 217 survey forms were distributed and 125 were returned. This represented a 58% response rate.

- 85% of patients found it easy to get through to this practice by phone compared to the CCG average of 71% and the national average of 73%.
- 94% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 74% and the national average of 76%.
- 98% of patients described the overall experience of this GP practice as good compared to the CCG average of 84% and the national average of 85%.
- 99% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 77% and the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received two comment cards which were both positive about the standard of care received. They told us they had not experienced any problems with the service provided by the practice and one told us that staff were helpful.

We spoke with three patients during the inspection. All three patients said they were satisfied with the care they received, that it was easy to make an appointment and that staff treated them with dignity and respect. We spoke with three members of the patients participation group (PPG), they were all positive regarding the standard of care provided by the practice. Two PPG members told us that they had never experienced any problems and that care was good. The other PPG member said they were treated with dignity and respect, but also spoke about potential lack of privacy in the nurses room as it was divided into three curtained off bays, and potential lack of confidentiality within the waiting area.

Outstanding practice

- Where staff showed an interest in a particular clinical area, the practice supported that member of staff to gain knowledge and skill in that area. If they were unable to drive to the location the practice financially supported them to physically access the training and paid staff overtime if training took place outside of their working hours.

St James Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to St James Surgery

The list size of the practice at the time of our inspection was 13,215. The practice list was closed by request of the practice; however negotiations are underway to reopen the list.

There are three male and two female GP partners. There is also one male salaried GP and two sessional GPs (these are effectively regular locums). There are three practice matrons (who are able to provide many services a GP can), one female nurse practitioner, five practice nurses and five female health care assistants (HCAs). There are a number of other staff carrying out administrative duties, led by a practice manager and assistant practice manager.

The practice is open between 8.30am and 6.30pm on Mondays to Fridays and Saturdays 8.30am to 12 noon. Each partner operated their own patient list to maintain continuity of care. When all slots for the session are full then a 'shared' list is operated. The practice has a nurse operated triage system for appointment requests, with a few exceptions, for example children.

Appointments times are from 8.30am to 12.30pm and 1.30pm to 6pm Monday to Friday and 8.30am to 11.30am on Saturdays.

When the practice is closed patients are advised to call 111 if they require medical assistance and are unable to wait until the surgery reopens. The out of hours service is provided by IC24.

The practice has lower than national average numbers of 0 to 49 year olds, and higher than the national average numbers of 65 to 85+ year olds.

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. The 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

Before visiting, we reviewed a range of information we hold about the practice. We carried out an announced visit on 18 October 2016.

During our visit we:

- Spoke with a range of staff including GPs, nursing and administration staff.
- Observed reception staff speaking with patients.
- Spoke with patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Detailed findings

- Reviewed an anonymised sample of the treatment records of patients.

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 were provided for specific groups of people and what good care looked 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).

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- We asked staff to explain the process of reporting significant events to us. They told us that they would either inform one of the management staff, either the practice manager or a GP, or complete a significant incident form. All significant events were discussed at the weekly GP meeting, and also shared at other staff meetings where staff learning was relevant to that staff group. For example, incidents affecting administration staff would be shared at their meeting.
- Significant incident forms and the evidence of the analysis showed that when a significant incident directly affected a patient: a thorough investigation was completed, the patient was informed of the incident, given information and appropriate support. A verbal or written apology was given, depending on the patients preference which would outline any actions taken to prevent the same thing happening again.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a significant event was discussed where an incorrect dose of a medicine was administered to a patient, this incorrect dose was repeated on subsequent administrations until a member of nursing staff uncovered the error. Processes and procedures surrounding administration of medicines were changed to prevent a reoccurrence of this incident. The incident was shared in the nurses meeting following investigation.

We reviewed safety records, incident reports, MHRA (Medicines and Healthcare Products Regulatory Agency) alerts, patient safety and minutes of meetings where these were discussed. The practice told us that the alerts were received by the practice manager and circulated to all clinical staff who decided what action needed to be taken. The practice employed a prescribing technician who conducted searches to establish if any patients were affected by medicines alerts. We found that any required action had been taken, for example, we viewed searches related to a medicines alert from February 2016, where appropriate follow up had taken place.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- There were established systems and processes in place to ensure patient safety and enable staff to identify and take appropriate action to safeguard patients from abuse. These systems took into account the latest relevant legislation and local council requirements. Staff were aware of their responsibilities regarding this. One of the GPs took the lead role for safeguarding. The GPs supplied reports as required for safeguarding meetings. Safeguarding concerns were discussed at regular multi-disciplinary safeguarding meetings which a variety of health and social care staff attended. Safeguarding was also on the practice agenda for staff meetings.
- Staff had received training on safeguarding children and vulnerable adults that was relevant to their role and at an appropriate level. We found that all GPs were trained to child protection or child safeguarding level 3.
- There was a notice near the clinical rooms advising patients that a chaperone was available for intimate examinations if required. Only staff that were trained for the role and had received a Disclosure and Barring Service (DBS) check were used as chaperones. Staff were aware of their responsibilities with regard to this role. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Patients were offered chaperones for intimate examinations.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. The nurse practitioner was the infection control lead. There was an infection control protocol in place and staff had received up to date training. Infection control audits were undertaken and actions identified and taken.
- Arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). There was a process in place for reviewing patients prescribed medicines requiring monitoring. There was a dedicated policy and a spreadsheet in place that was monitored by a named member of staff. We checked and found the process to be effective.

Good

Are services safe?

- The practice monitored their performance using benchmarking data, with the support of the local medicines management team and their own prescribing clerk, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and a system in place to monitor their use. Patient Group Directions had been adopted by the practice to allow practice nurses to administer medicines in line with legislation. The health care assistant was trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely and securely. There were also arrangements in place for the destruction of controlled drugs.
- We reviewed six personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. The practice had a system to ensure ongoing checks related to registration with professional bodies and immunisation status of staff.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- The practice had systems in place to assess and monitor risks to staff and patients. There was a contract in place with an external company to check that all clinical and electrical equipment was safe to use and working properly. There were also risk assessments in place for infection control, health and safety, control of substances hazardous to health (COSHH), fire and Legionella testing, as well as fire drills. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). There were also specific risk assessments for staff, for example pregnancy risk assessments.
- The practice had a rota system to ensure there were sufficient staff with an appropriate skill mix, and staffing levels were determined by practice manager. The practice had had difficulties recruiting GPs therefore had recruited nurse matrons to provide some of the services that would have been provided by GPs.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an alert button on the computers in all of the consultation and treatment rooms which staff could press to summon other staff in an emergency situation.
- Staff had received training on basic life support and use of a defibrillator. There was a defibrillator available on the premises. Oxygen was in an accessible place.
- We spoke with staff regarding emergency medicines and found that they were kept in a secure area of the practice that was easily accessible to staff in the case of an emergency. We checked the medicines and found them to be appropriate, stored securely and within their expiry date, with a system for checking the dates in place.
- The practice had a business continuity plan in place for major incidents such as IT failure or flooding. The plan included emergency contact telephone numbers for relevant utilities and contact details for staff members. Copies were kept off site.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff had access to guidelines from National Institute for Health and Care (NICE) and other online resources and used this information to deliver care and treatment that met patients' needs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice).

- The most recent published results, from 2014 to 2015, indicated the practice achieved 99% of the total number of points available compared with the CCG average of 92% and the national average of 95%.

This practice was not an outlier for any QOF clinical targets. Data from 2014 to 2015 showed:

Performance for diabetes related indicators was in line with or higher than the CCG and national average. For example, the percentage of patients with a record of an annual foot examination and risk classification was 95% compared to the CCG average of 92% and national average of 88%. The practice had a 6% exception reporting rate which was in line with the CCG average of 5% and lower than the national average of 8%. (The QOF includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.)

Performance for mental health related indicators was higher than the CCG and national average. For example, the percentage of patient's, with a diagnosis of schizophrenia, bipolar affective disorder and other psychosis, who had had an agreed care plan documented in their records was 95% compared to a CCG and national average of 88%. The practice had a 7% exception reporting rate which was lower than the CCG average of 9% and much lower than the national average of 13%.

The practice data for the number of antibacterial medicines prescribed was in line with the CCG and national average. The practice had a prescribing clerk who monitored their performance using benchmarking data from the local CCG. They also conducted a number of searches to ensure optimised prescribing on a cost-effective basis.

The practice levels of exception reporting for some indicators was higher that the CCG and national average. For example, exception reporting for asthma related indicators was 13% overall compared with 5% CCG average and a 7% national average. We viewed the unpublished QOF data for 2015/2016, which is the latest full year, and found that this had been addressed and their exception reporting was lower than CCG and national average for all indicators. For example, their exception rate for asthma for 2015/2016 was 2%.

There was evidence of quality improvement including clinical audit:

- We viewed two full cycle (audited and re-audited) clinical audits completed in the last two years. One related to patients with heart failure and demonstrated a 37% increase in optimal therapy over 6 months. The second related to stable angina and showed an increase in the number of patients prescribed the optimal dosage of calcium channel blockers (a medicine used as an alternative to beta blockers as first-line treatment for stable angina).
- We found that the practice participated in local and national benchmarking and had systems in place to ensure that their performance was both maintained and improved.

The practice lost two of its GP partners and was unable to recruit more to the practice. They were concerned that their ability to maintain a good standard of care to patients would be compromised if they continued to accept new patients on their list without sufficient resources. They successfully negotiated for a temporary closure of their patient list until they were able to recruit and train additional clinical resources. New-borns and returning students were still accepted.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

Good

Are services effective?

(for example, treatment is effective)

- The practice had an induction programme for all newly appointed staff. Core training for staff covered such topics as safeguarding, infection prevention and control, fire safety, health and safety, information governance and confidentiality.
- Staff received role-specific training and updating as relevant. For example, for those reviewing patients with long-term conditions. Staff administering vaccines and taking samples for the cervical screening programme had received specific training.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. Any other clinical interests were encouraged and additional learning supported by the partners. This included ongoing support, informal one-to-one meetings, mentoring and support for revalidating GPs. We found that all staff had received an appraisal which included a personal development plan. It was evident that the process was a two way one in which staff were able to contribute their thoughts and aspirations.

Coordinating patient care and information sharing

Staff had access to information they required to plan and deliver patients' care and treatment through the practice's records system and their intranet system. This included care and risk assessments, care plans, medical records and investigation and test results.

The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a regular basis when care plans and actions were routinely reviewed and updated for patients with complex needs and adult or child safeguarding concerns. Staff liaised with other professionals on outside of these meetings too. Staff had working relationships with school nurses, health visitors, social workers, community matron and other community nurses.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Staff were able to give us examples that showed that when providing care and treatment for children and young people, they carried out assessments of capacity to consent in line with current relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the clinical staff assessed the patient's capacity and documented this appropriately.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Health promotion advice and blood pressure checks were available from practice staff.
- There was smoking cessation available onsite
- Those with other needs were signposted to the relevant services.

The practice's uptake for the cervical screening programme was 95%, which was higher than the CCG average of 83% and the national average of 82%. There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Data for other national screening programmes such as bowel and breast cancer showed that the practice uptake was in line with CCG and national averages. For example, the uptake of screening for bowel cancer by eligible patients in the last 30 months was 57% for the practice, compared to 60% average for the CCG and 58% national average. The uptake of screening for breast cancer by eligible patients in the last 36 months was 76% for the practice, compared to 75% average for the CCG and 72% national average.

The amount of patients with a diagnosis of cancer on the practice register was 0.9% higher than the CCG average and 1.2% higher than the national average.

Childhood immunisation rates for the vaccinations given were higher than CCG and national averages. For example,

Good

Are services effective?

(for example, treatment is effective)

- The percentage of childhood 'five in one' Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenza immunisation vaccinations given to under one year olds was 98% compared to the CCG percentage of 95% and the national average of 93%.
- The percentage of childhood Mumps, Measles and Rubella vaccination (MMR) given to under two year olds was 98% compared to the CCG percentage of 93% and the national average of 91%.
- The percentage of childhood Meningitis C vaccinations given to under five year olds was 97% compared to the CCG percentage of 96% and the national average of 83%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Where abnormalities or risk factors were identified during these health checks, these were followed up appropriately.

The practice also completed preschool checks for children on their list.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were polite to patients, tried to accommodate their preferred requests for appointments and other items and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- We saw a notice advising patients that a private area could be offered if they wanted to discuss issues privately. Staff could also use this if patients appeared distressed.

Both patient Care Quality Commission comment cards we received were positive about the service experienced. The comments cards said they felt the practice offered a good service and one said staff were helpful and friendly.

We spoke with three members of the patient participation group (PPG). They were positive about the care they received and felt they were treated with dignity and respect. The three patients we spoke with during our inspection also confirmed this.

Results from the national GP patient survey, published in July 2016, showed patients felt they were treated with compassion, dignity and respect. The practice was in line with or above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 94% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 94% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%.
- 95% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national average of 85%.
- 92% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 91%.
- 95% of patients said they found the receptionists at the practice helpful compared to the CCG and national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They felt treatment options were explained enabling them to make an informed decision about care and treatment.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 89% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 90% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 82%.
- 90% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG and national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- There were translators available.
- There was a portable hearing loop available.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of local and national support groups and organisations. For example, carer support agencies.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 322 patients as carers (2.4% of the practice list). They had a member of staff responsible for signposting carers to support and a

Good

Are services caring?

carers pack as well as links to useful websites on their own web page. There was also a visiting care advisor who held a weekly clinic in one of their rooms to provide assistance with form filling and so on.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice were aware of the needs of their patient population:

- Extended hours were available on a pre bookable basis every Saturday morning.
- Flu vaccination clinics were held three Saturdays in a row.
- The practice had changed to a triage appointments system to ensure that patient who needed to be seen on the same day were.
- Longer appointments were available for those patients that required them.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Patients were able to receive travel vaccinations available on the NHS, and some others only available privately.
- A baby changing mat was available upon request.
- Translation services were available via telephone.
- The practice had an accessible toilet on the ground floor and ramped access into the practice building.
- Abdominal Aortic Aneurysm clinics were held within the practice.
- Patients were personally called to the consultation rooms by the doctor, nurse or health care assistant.

Access to the service

The practice was open between 8.30am and 6.30pm Monday to Friday. Appointments were from 8.30am to 12.30pm and 1.30pm to 6pm daily. The practice was open Saturdays 8.30am to 12 noon for pre-booked appointments.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was above the local and national averages.

- 89% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and a national average of 79%.
- 85% of patients said they could get through easily to the practice by phone compared to the CCG average of 71% and the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The policy for home visits was available on the practice website for patients to view. Patients were encouraged to ring between 8.30am and 10.30am for home visit requests. Basic information would be taken by the receptionist and then requests were passed to the duty doctor who would contact the patient for more details, prior to determining the necessity for a visit. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling comments, complaints and concerns.

- The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager handled all complaints in the practice, with clinical input from the GPs.
- We saw that there were leaflets for patients to complete in the waiting area with a posting box and information on the website to help patients understand the complaints system.

We looked at six complaints received in the last 12 months in detail and found these were satisfactorily handled and there was openness and transparency with dealing with the complaint. Lessons were learnt from individual concerns and complaints and action was taken as a result to improve the quality of care. For example, one complaint related to patient treatment by a clinician. The clinical notes were reviewed by the GP and a written response given which evidenced the reasons why certain actions were taken. Where there was learning from complaints we saw evidence that these were discussed at either clinical or practice meetings.

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 partners promoted a high standard of performance in staff to achieve good outcomes for their patients. They had supported and invested in their staff to enable that to happen.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy, good quality care and encouraged improvement.

- There was a clear staffing structure and staff we spoke with were aware of their own roles and responsibilities and those of other staff.
- The practice had an effective system in place for monitoring and assessing the quality of services provided through quality improvement. The practice compared local and national data against their own performance and were aware of their ongoing performance against national targets. The practice used a variety of different methods to maintain and improve the standard of care provided to patients, including audits and benchmarking.
- There were practice specific policies which were implemented, updated and were available to all staff.
- There were arrangements in place for identifying, recording, reviewing and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection staff told us the partners were approachable and were open to suggestions for improving the way elements of the service were delivered. We saw that when they encountered an obstacle to providing good quality care they ensured that existing patients had their needs met and thought of innovative solutions to the problem.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty which was evident throughout our inspection. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, information and a verbal or written apology, depending on the circumstances.
- The practice kept records of written correspondence.

There was a clear leadership structure in place and all staff felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us they had the opportunity to raise any issues both at team meetings and outside of these and felt confident that action would be taken to resolve these concerns.
- Staff told us that they felt involved in the development of the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys, comments and complaints received. For example, one patient wrote to the practice to say it would be good to have somewhere to secure their bicycle so the practice commissioned a bicycle rack to be installed at the front of the practice in the car park. The PPG was a virtual membership and the practice used it to give them feedback on the practice and the service they provided.
- The practice had gathered feedback from staff through staff meetings, appraisals and informal conversations. Staff were able to give examples of where they had identified improvements to processes and how they had been supported to make those changes.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The partners encouraged staff to pursue clinical interests. They paid staff

Are services well-led?

Good

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

overtime if training was outside of their standard working hours and paid for taxis if the location of the training meant that this form of transport was the only option to get from train to the venue.