James Alexander 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?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at James Alexander Family Practice on 30 August 2017. Overall the practice is rated as good.

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

- The practice had become registered with the Care Quality Commission in May 2016 and was on a trajectory of improvement. This was a new registration following a practice split. Some initiatives such as improvement in patient satisfaction scores and Quality outcomes framework were not demonstrable in the national figures quoted as they included some data from the previous governance team but we saw evidence of improvement on the day of inspection.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke very highly of the culture. There were consistently high levels of constructive staff engagement.
  - Staff at all levels were actively encouraged to raise concerns.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Staff told us that they had seen many improvements in the practice since registration.
  - The practice had strong and visible clinical and managerial leadership and governance

Summary of findings

arrangements. The practice had funded leadership training for two of the key members of staff. This had resulted in nominations by practice staff and also from doctors training at the practice for awards in inspirational leader and best team categories.

- The practice proactively sought feedback from staff and patients, which it acted on.
  - The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example a jointly funded pilot scheme had recently been completed; evaluation had shown a reduction in pain and an improvement in mental well-being in patients suffering from arthritis and multiple sclerosis. This was due to be presented to local commissioners with a view to becoming shared across the area.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
  - Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
  - The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example; the practice had introduced GP telephone triage, introduced a new automated telephone system and recruited staff to build a multi-disciplinary team to suit the needs of their patients.
- The practice actively reviewed complaints and how they were managed and responded to, and made improvements as a result.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.

We saw areas of outstanding practice:

- Members of staff were inspired to care for patients and we saw numerous examples of this care.
- The practice had recognised that Hull had the highest incidence of Ischaemic Stroke in England and was an outlier. The practice had funded equipment to screen patients for atrial fibrillation and had identified patients with previously undiagnosed atrial fibrillation who were now receiving treatment. This indicated undiagnosed atrial fibrillation in almost 10% of patients tested. They were in negotiation with the CCG to be a pilot for this service with the aim of roll out across the area.

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.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and had received/were booked in to receive training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were comparable to the national average.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easily accessible.

Summary of findings

- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- There was a strong, visible, person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who use the service, those close to them and staff were strong, caring and supportive. These relationships were highly valued by all staff and promoted by leaders.
- People's emotional and social needs were seen as important as their physical needs.
- We observed a strong patient-centred culture: We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on.
- Views of external stakeholders were very positive and aligned with our findings.
- Members of staff were inspired to care for patients and we saw numerous examples of this care including; collecting prescriptions for patients who were unable to get out, doing shopping for a patient with no food in the house and engaging a patient with mental health problems in a bicycle ride.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning services that met patients' needs. For example; the practice had recognised that screening rates were lower than average and had employed a Service Development Nurse who had organised a two day health promotion event in the local shopping centre.
- There were innovative approaches to providing integrated patient-centred care. The practice had identified that the practice population lived in an area where there was a high incidence of Ischaemic Stroke and was an outlier. They had purchased equipment to screen patients for atrial fibrillation, a condition that may lead to stroke.
- The individual needs and preferences of people with a life-limiting condition, including patients with a condition other than cancer and patients living with dementia, were central to their care and treatment. Care delivered was flexible and provided choice. The practice had effectively established a social prescribing system whereby a volunteer attended the practice every week to provide advice to their patients on a wide range of social problems. We were shown evidence that 45 patients had been signposted to the correct help for a number of different problems such as suicidal thoughts, loneliness,

domestic abuse, homelessness through to benefits advice. We saw that the practice had gathered feedback from each patient and nearly all of the comments were that they were helpful, supportive and understanding.

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. They had introduced a system called correspondence management whereby trained staff were responsible for reviewing all inward correspondence which meant that GP's had more time to see patients.
- Patients could access appointments and services in a way and at a time that suited them. The practice had introduced GP telephone triage, introduced a new automated telephone system and recruited staff to build a multi-disciplinary team to suit the needs of their patients. Staff had received further education to enable them to direct patients to the correct practitioner.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from eight examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding ☆

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

The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care.

The strategy and supporting objectives were stretching, challenging and innovative, while remaining achievable.

A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.

Governance and performance management arrangements are proactively reviewed and reflect best practice.

Leaders had an inspiring shared purpose, strove to deliver and motivate staff to succeed.

There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive staff engagement. Staff at all levels were actively encouraged to raise concerns.

Summary of findings

There was strong collaboration and support across all staff and a common focus on improving quality of care and people's experiences.

Innovative approaches were used to gather feedback from people who use services and the public, including using a token system to assess patient satisfaction.

Rigorous and constructive challenge from people who use services, the public and stakeholders was welcomed and seen as a vital way of holding services to account.

The leadership drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment.

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.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.

People with long term conditions

Good

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

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- In the last reported data the percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less was 69% which was 11% below the national average. This was data relating to the previous governance, the practice had recognised this and recent data provided by the practice on the day of the inspection showed an improvement to 78%.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.

Summary of findings

- The practice were proactively screening patients for chronic obstructive pulmonary disease and atrial fibrillation as they were aware that the figures for patients diagnosed with the disease were lower than expected.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- On the day of inspection we saw that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

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 these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours and telephone appointments.

Summary of findings

- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice had recognised that screening rates were lower for their patients and planned to have a two day event in a local shopping centre to raise awareness.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations. They had organised for a volunteer from a local organisation to attend weekly for any patients wanting advice on social prescribing.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours 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).

- The practice carried out advance care planning for patients living with dementia.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.

Summary of findings

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive care plan documented in the record, in the preceding 12 months was 96% which was above the national average.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia. The practice was dementia friendly and had named staff who trained, advised and signposted patients to support.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 6 July 2017. This showed the practice was performing lower than local and national averages. 392 survey forms were distributed and 101 were returned. This represented 3% of the practice's patient list.

- 69% of patients described the overall experience of this GP practice as good compared with the CCG average of 83% and the national average of 85%.
- 57% of patients described their experience of making an appointment as good compared with the CCG average of 69% and the national average of 73%.
- 58% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 77%.

These figures related to the period of January to March 2017. The practice had recognised this and recruited staff and implemented several different patient feedback collection methods. These included token boxes, social media, patient satisfaction surveys with clinician specific and also service specific feedback. The results were reviewed as a standing agenda item in management meetings every four weeks. Recent patient surveys done by the practice were much improved, for example;

Recent feedback regarding patient satisfaction with care provided was that 91% were satisfied or extremely satisfied.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 23 comment cards which were all positive about the standard of care received. Key points were that patients felt treated with care and respect and that the practice offered an excellent service.

We received seven patient questionnaires during the inspection. All seven patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The practice's friends and families test results from June to August 2017 indicated that 82% were likely or extremely likely to recommend. Friends and family responses had increased from 0-3 responses monthly to 58 responses in July 2017 due to the practice raising patient awareness.

Outstanding practice

- Members of staff were inspired to care for patients and we saw numerous examples of this care.
- The practice had recognised that Hull had the highest incidence of Ischaemic Stroke in England and was an outlier. The practice had funded equipment to screen patients for atrial fibrillation and had identified patients with previously undiagnosed atrial fibrillation who were now receiving treatment. This indicated undiagnosed atrial fibrillation in almost 10% of patients tested. They were in negotiation with the CCG to be a pilot for this service with the aim of roll out across the area.

James Alexander Family Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to James Alexander Family Practice

James Alexander Family Practice, Goodhart Road, Bransholme, Hull, North Humberside HU7 4DW is a GP practice in Hull situated in a modern accessible building which is leased from Community Health Partnership CIC. There are also six other GP practices in the building and a range of community health services. The practice registered with the Care Quality Commission in April 2016 and has seen several changes such as relocation in the building to the second floor in September 2016. The practice have been recruiting staff since then and have recently recruited four Nurse Practitioners who are due to start in the next couple of months. The practice place emphasis on a multi-disciplinary team approach to patient care. The current staff are;

Two male GP partners, one full time and one part time, two salaried GPs (one male and one female), a Nurse Practitioner (female) and a Advanced Nurse Practitioner who is able to prescribe (male), three Practice Nurses (all female), two Health Care Assistant (both female) and a Clinical Pharmacist. The practice is supported by an Operational Lead, a Branch Manager, a Service Development Nurse, Office supervisor, Secretary, and a range of administrative and reception staff.

The practice has a General Medical Services contract. It has approximately 7300 patients mainly from a white British background. The practice is in an area measured as having high levels of deprivation and is scored as one on the indices of deprivation. Practices with high levels of deprivation typically have more need for health care services. It is a teaching and training practice to both nursing staff, medical students, junior doctors and GP trainees and participates in research. There is a large car park and good transport links.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are available from 8am every morning to 6.20pm daily. Extended hours appointments are offered on Wednesday evening each week until 8pm.

When the practice is closed patients are advised to contact the Out of Hours service (111) provided by City Health Care Partnership CIC in Hull.

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 and asked other organisations such as the Clinical Commissioning Group and Healthwatch to share what they knew. We carried out an announced visit on 30 August 2017. During our visit we:

- Spoke with a range of staff including GP's, a Nurse Practitioner, a Practice Nurse, Service development nurse, the Operational Lead, Branch Manager and reception and administrative staff and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards and questionnaires where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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 living 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 a system for reporting and recording significant events.

- Staff told us they would inform the branch manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under 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).
- From the sample of documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable. They received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a new protocol for sharing medical records was formulated following an incident at the practice.
- The practice also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff and we were told they were due to be updated. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training or were due to receive training on safeguarding children and vulnerable adults relevant to their role. GPs and Nurse Practitioners were trained to child protection or child safeguarding level three and Practice Nurses to level two.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. One of the nurse practitioners and the clinical pharmacist had qualified as Independent Prescribers and could therefore prescribe medicines for clinical

conditions within their expertise. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

The practice recruitment policy detailed appropriate recruitment checks which should take place prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

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 were 95% of the total number of points available compared with the clinical commissioning group (CCG) average of 92% and national average of 95%. However this data was from the period 01/04/2015 to 31/03/2016 and therefore related to the previous governance of the practice. We reviewed data relating to the period 2016 to 2017 which showed an improvement in the total number of points from 95% to 97%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/2016 showed:

- Performance for diabetes related indicators was mixed compared with the CCG and national averages. However the exception reporting was significantly higher at 22.5% compared with 15.8% locally and 11.6% nationally. On the day of inspection we were shown evidence that the exception reporting was now significantly lower at 12.8%.
- Performance for mental health related indicators was better than the CCG and national averages.

  These figures related to historic data prior to the current practice team's governance. On the day of the inspection we were shown that QOF figures had improved and the practice had taken steps to ensure this continued, for example with a lead member of staff for QOF. For example;
- Performance for diabetes related indicators had mainly improved, the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg was comparable at 66% and the percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 moll/l or less was now 78% as opposed to the previous figure of 69%.

There was evidence of quality improvement including clinical audit:

- There had been several clinical audits commenced after April 2016, the practice had not yet had time to make all of them completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, recent action taken as a result of an audit of patients with hypertension helped to ensure that they had been correctly diagnosed with NICE guidance gold standards, this also provided more effective use of the health care assistant's time freeing up more appointments.

Information about patients' outcomes was used to make improvements such as: the practice had carried out a medication review audit from May 2017 on patients who had not had a medication review within the last year. At the beginning of the audit this stood at 11% outstanding but following re-audit this was now at 2%.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.

Good

Are services effective?

(for example, treatment is effective)

- One of the GPs was the medical lead for the Community Stroke Rehabilitation Service, providing medical support to patients in Rossmore Community Stroke Rehabilitation Unit.
- One of the GPs was the Educational and Clinical Supervisor for Year five Medical Students and a GP trainer.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- 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. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. However we found that compliance rates for updates on basic life support training was 65%, fire safety awareness 62% safeguarding children 48% and safeguarding adults 52% and information governance 48%. Following the inspection we were provided with evidence that compliance rates had increased to 92% for basic life support, 88% for fire safety awareness, 80% for both safeguarding children and adults and 84% for information governance. Staff had access to and made use of e-learning training modules and in-house training.
- Reception staff had been upskilled in signposting patients to the correct care giver.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From sampling documented examples we reviewed we found that 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. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

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

- < >taff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

Good

Are services effective?

(for example, treatment is effective)

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- The practice were organising a two day health promotion event in the local shopping centre to raise awareness of screening as the screening rates were historically low in the area.
- Individual working groups had been set up in the practice, this involved members of staff choosing a patient group to try to identify areas where they could improve services.
- A dietician was available on the premises and smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 74%, which was lower than the CCG average of 81% and the national average of 81%. The practice was aware of this and planned to raise awareness of screening at an open day event they had planned.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages. For example, rates for the vaccines given to under two year olds were on average 90% and five year olds on average 83% in the last year.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. There were failsafe systems 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.

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. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

All of the 23 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We reviewed seven patient questionnaires and spoke with a member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 85% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 82% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 86%.
- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%
- 83% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 86%.
- 91% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 91%.
- 85% of patients said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 99% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 97% and the national average of 97%.
- 84% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 71% of patients said they found the receptionists at the practice helpful compared with the CCG average of 86% and the 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 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 available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals.

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

- 83% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 84% and the national average of 86%.
- 74% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.

Good

Are services caring?

- 86% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 90% and the national average of 90%.
- 83% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.
- Eight members of staff were completing sign language training.
- A volunteer from a local women's centre visited the practice every week to offer social prescribing advice to patients who needed this.

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 support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 125 patients as carers (1.7% of the practice list) and these patients had been referred to the Carers Association. Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support.

A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective.

Two members of staff acted as dementia champions.

We were told about numerous examples of caring staff attitudes, for example;

- A member of staff on a home visit realised that the patient had no food so did food shopping for them in his own time.
- Staff collecting prescriptions for patients who were unable to get to the chemist
- Drawing competitions for children.
- Staff members took part in the Alzheimer's Society memory walk in September on behalf of James Alexander Family Practice and had a team donation page. Information was also passed to patients if they wished to take part in the walk themselves.
- The practice holds a 'Cupcake Day' on behalf of Alzheimer's Society. Staff members provide cakes and drinks for donations and patients are welcome to provide anything if they wish.
- The practice planned to host 'Crafternoon' – a mental health awareness day which is an event on behalf of MIND. This would allow patients & staff to take part in crafting.
- The practice had applied to be a food bank distributer.
- A member of staff had gone for a bike ride with a patient who was suffering with mental health problems. The practice were now looking into setting up a cycling club.
- Examples of staff members sitting with patients who were lonely and having a cup of tea.
- Christmas jumper day:£177.55 was raised for Save the Children.
- The practice held a Macmillan Coffee Morning and raised £313.91 in 2016 and there were plans in place for another event shortly.

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service.

Good

Are services caring?

One of the GP partners had a special interest in palliative care and had completed extended training in this area, working as a Macmillan GP in a Specialist Palliative Care Clinic.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours one evening per week until 8pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation. Clinical triage was commenced at 8am by a GP.
- The practice sent text message reminders of appointments and test results.
- An On-line Messaging service had been implemented.
- Patients were able to receive travel vaccines available on the NHS and were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- A new system had been implemented in July 2017 with the aim of reducing patients who did not attend (DNA). This involved the patient receiving a phone call from the practice if they failed to attend and was to be audited to assess the impact.
- Voice Connect allowed patients to either book the next available appointment or with a specified clinician.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.
- The practice has considered and implemented the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.
- The practice had recognised that Hull had the highest incidence of Ischaemic Stroke in England and was an outlier. The practice had funded equipment to screen patients for atrial fibrillation and had screened 31 patients within two weeks at the time of the inspection. They had identified three patients with previously undiagnosed atrial fibrillation who were now receiving treatment. This indicated undiagnosed atrial fibrillation in almost 10% of patients tested. They planned to implement opportunistic screening to all patients over 18 years of age and were in negotiation with the CCG to be a pilot for this service with the aim of roll out across the area.
- The practice had installed Radio Streaming – this was now active in the waiting room through radio on the front desk. The recent token box survey showed an 88% patient satisfaction for music being played through the surgery. The practice had implemented token box surveys at the reception desk. They updated questions every four weeks and collating data to provide to patients.
- The practice had arranged for a patient representative to be present during interviews for new staff members.
- The practice had worked in collaboration with local services and jointly funded a pilot for patients suffering from pain relating to arthritis and multiple sclerosis. This was delivered by micro-current electrical therapy. Initial audit of this Action Potential Simulation (APS) Therapy was that pain was reduced by 42% in multiple sclerosis patients and 34% in arthritis sufferers. Mental well-being had improved by 26% in arthritis sufferers and 31% in multiple sclerosis patients. The findings of this were due to be presented to the CCG later in the year.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were available from 8am until 6.20pm. Extended hours appointments were offered on Wednesday evenings per week. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 64% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 76%.
- 50% of patients said they could get through easily to the practice by phone compared to the national average of 71%.
- 69% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 80% and the national average of 84%.
- 66% of patients said their last appointment was convenient compared with the CCG average of 78% and the national average of 81%.
- 57% of patients described their experience of making an appointment as good compared with the CCG average of 69% and the national average of 73%.
- 51% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 62% and the national average of 58%.

The practice had recognised these figures and implemented measures to improve patient satisfaction with access. These figures related to January to March 2017 and we saw evidence that patients' satisfaction had improved. The practice had recently sought feedback on services implemented to address these issues and results were positive with 78% of 323 responders indicating they were happy with the new automated telephone system and the improved access to care it provided. Measures implemented by the practice included telephone triage during busy periods and a wall board with live feed back to the doctor when there were too many patients waiting. The practice had also recruited new members of staff to enable them to offer more appointments and therefore enhance the patient experience. The additional four Nurse Practitioner hours would equate to an extra 10,000 appointments a year.

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

The practice had a system to assess:

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

The GP on call would do this by telephoning the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. 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. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. This was in the form of a summary leaflet.

We looked at eight complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and with openness and transparency. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken as a result to improve the quality of care. For example, following a complaint regarding the management of an acute abdominal condition the clinical team created structured easy to follow management plans with the patients involvement, the condition was reviewed by the clinical team in a meeting and the GP involved completed an e-learning module on the conditions.

Are services well-led?

Outstanding ☆

(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 practice had separated from another practice in the area and could demonstrated improvements since the split in the areas of QOF, leadership, staff development and innovation. We were told that the practice wanted to offer accessible and less invasive health care to patients. We heard from staff that they were fully supportive of the vision of patient centred care and teamwork.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example staff members were in groups to identify ideas for improvement in service delivery for each of the patient populations groups and there was a lead member of staff for QOF.
- The practice were placing emphasis on developing a non-medical workforce to meet the needs of their patients and aim to address the GP recruitment problems.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff. They told us they placed a high emphasis of patient views and services were developed in collaboration with patients for patients.

- One of the GP partners and the practice Operational Lead had completed an NHS Leadership course. This had enabled the practice to identify which staff to upskill in which areas in the organisation. These extensive training courses were funded by the practice with the aim of the development of higher level leadership skills.
- The practice had completed the Organisational Culture Inventory chart in August 2016 and then redone it in August 2017. This was a staff survey and data clearly demonstrated a significant increase in levels of staff satisfaction and people orientated approaches indicating effective leadership since the organisation of the practice had changed in April 2016.
- The practice had recently appointed a Service Development Nurse to respond to patients' needs, promote health and drive improvement in outcomes for their patients. A two day health promotion event had already been organised in the local shopping centre.
- The practice had completed the Investors in people accreditation.
- Staff told us that there was no hierarchy in the practice.
- Patients were on interview panels.
- We were told of numerous examples of innovations and ideas that were in infancy such as targeting patients who attended for flu clinics to increase awareness of health screening, collaborative working with the Local Authority to promote health promotion on the council

Are services well-led?

Outstanding ☆

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

website, opportunistic screening of cholesterol and atrial fibrillation. There were also plans to have a paramedic on placement in the practice to provide triage and acute care.

- The practice had been nominated by medical students for the Hull York Medical School (HYMS) team of the year award and won runner up.
- One of the GPs was shortlisted and became the runner up in the North Yorkshire Leadership Academy's "Inspirational NHS Leader of the year" award 2016.
- The practice was part of the Hull GP Collaborative Ltd with the aim of working at scale with a patient population of 70,000.
- The practice had devised a Correspondence Management Policy which gave clear guidance of the standard procedure to be followed for the management of patient information and documentation by the non-clinical Correspondence Management Team. The overall outcome of this policy was that it saved 7.5 hours per week of GP time, which equated to a saving of 94 GP sessions per year.
- We were provided with a summary of the outcomes and reception time saved by the implementation of a new automated telephone system - Patient Partner. This revealed a receptionist time saving of approaching 100 hours, therefore freeing up that time to engage in additional tasks.

The provider was aware of and had systems 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).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. From the sample of six documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt much supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view.
- The practice worked in collaboration with local practice s and had joint education meetings.
- Staff overwhelmingly said they felt respected, valued and supported, particularly by the lead partner in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, a radio had been introduced in the waiting area to promote privacy and dignity.
- the NHS Friends and Family test, complaints and compliments received
- staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt fully involved and engaged to improve how the practice was run. Many members of staff told us that the new leadership had turned the practice around and that is was a fantastic place to work.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes

Are services well-led?

Outstanding ☆

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

to improve outcomes for patients in the area. The practice were hoping to increase their skill mix with the recruitment of a Community Psychiatric Nurse, pharmacy technicians and a paramedic. There were plans for more collaborative working across practices in the area. There were many examples of innovation and change that would not yet be demonstrable and the practice was on a trajectory of improvement with a strong desire evident to make it an outstanding place for patients and staff.