St. James Surgery

Quality Report

89 Wash Lane,
Clacton on Sea,
CO15 1DA
and
Church Square Branch Surgery,
St Osyth,
Clacton on Sea,
CO16 8NU
Tel: 01255 222121
Website: 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.

Summary of findings

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Summary of findings

Overall summary

St James is a GP practice providing primary care services to patients in Clacton. It provides primary care services from two sites, one at Wash Lane, Clacton, and a branch surgery at Church Square in St Osyth. We did not visit the branch surgery on this inspection.

All the patients we spoke with were complimentary about the service they had received. The results of the most recent patient survey carried out by the practice showed that patients were satisfied with the care and treatment they received.

We saw evidence that the practice responded promptly and effectively to incidents and complaints. The practice had learned from these events and made improvements.

Throughout the inspection we saw the leadership team was visible, and staff and patients found them approachable and supportive.

We saw that the practice had taken steps to ensure the service delivered was safe for patients as well as to the staff employed there. There were systems in place to ensure effective patient care and we heard about a high level of patient satisfaction with the care and treatment provided.

Patients were treated with dignity and respect in a well maintained environment which was accessible and had features that ensured patients' privacy. The appointment system enabled patients to be seen quickly for the amount of time their needs required. The practice was responsive to the needs of patients and continuously strived to improve the service it provided through active engagement with the patient group. The practice was well led by the practice manager supported with a deputy and the partner GPs. They were supported by an engaged practice nursing and staff team.

Patients over the age of 75 were allocated a dedicated GP to oversee their individual care and treatment requirements delivered in the practice or in the patient's own home.

Mothers, babies, children and young patients had access to specialised staff as well as dedicated clinics and health promotion materials.

The practice have made provision for the working-age population and those recently retired with some evening and early morning appointments as well as telephone consultations.

Patients not registered with St James surgery could access services there. Patients in vulnerable circumstances who may have poor access to primary care were also provided with services by the practice.

Patients experiencing poor mental health had access to psychiatric care and local counselling. Once diagnosed with poor mental health patients were monitored and offered six-monthly check-ups.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The service provided was safe.

The people using the service, those close to them and staff were protected from avoidable harm. Patients we spoke with said they felt safe. Safety was a priority. Staff took an active role in delivering and promoting safety. The practice understood risks, had a clear picture of safety and was focused on improvement. The practice had a track record on safety performance that showed on-going improvement. Concerns were dealt with quickly and effectively.

Systems, processes and standard operating procedures promoted safe care, were reliable and reflected relevant guidelines. This included the approach to infection prevention and control; the building layout, cleanliness and maintenance of facilities; use and maintenance of equipment; medicines management; records management and staff recruitment checks.

Staffing levels were set and reviewed to keep people safe and meet their needs at all times the practice was open. Risks to individuals were effectively assessed and managed, including clinical and health risks and risks of harm to the patient and to others. Patients were involved and risk assessments were person-centred, proportionate and reviewed regularly.

There were emergency preparedness and incident plans in place.

Are services effective?

The service provided was effective.

Patients received care, treatment and support that achieved positive outcomes, promoted quality of life and was based on the best available evidence. National evidence-based best practice, professional standards and expert guidance were used routinely. They were appropriately tailored to meet the needs of patients who used services.

Patients' needs were assessed appropriately and care and treatment was planned and delivered in line with current legislation, standards and nationally recognised evidence based guidance. This included assessments of capacity and the promotion of good health.

Summary of findings

There was a multi-disciplinary collaborative approach to care and treatment. There was proactive engagement with other health and social care providers and joint working arrangements in place with effective communication, information sharing and decision making about a patient's care.

Are services caring?
The service provided was caring.

Feedback from patients who use the service, those who are close to them and stakeholders was positive about the way staff treated patients. Staff treated patients who use the service and those close to them with dignity and respect. Patients felt supported and well-cared for as a result.

All staff involved patients who use the service as partners in their own care and in making decisions, with support where needed, including support from advocates. Family, friends and advocates were involved as appropriate and according to the patient's wishes.

Are services responsive to people's needs?
The service provided was responsive.

Patients received care which met and responded to their needs. The staff at the practice understood the different needs of the patients. Services were designed and delivered to meet those needs. This included active engagement with stakeholders to provide coordinated pathways of care.

Patients were able and supported to access the right care at the right time. Appointments systems were easy to use and supported choice. Patients waited as short a time as possible for services, treatment or care. There was an effective and proactive approach to managing referrals and appointments.

Patients were encouraged to have the information they need prior to decisions made on treatment referrals and were supported to provide feedback or make a comment or complaint about their care. Patients were listened to and treated with respect when they raised concerns; they were involved in the process and received feedback. The practice continuously reviewed and acted on feedback and complaints about the quality of care and used this information to improve services. The practice was open and honest about the learning and action they had taken.

Are services well-led?
The service provided was well-led.

Summary of findings

All staff knew their responsibilities and the limits of their authority. The leadership team communicated effectively and worked collaboratively with staff. Staff felt respected, valued and supported.

Risks to the delivery of quality care were identified, analysed and those risks mitigated systematically. Issues were minimised and action taken swiftly. A proactive approach was taken to seek a range of feedback from patients, the public and staff. Patient and staff concerns were heard and acted upon.

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

Care was tailored to individual needs and circumstances, including a patient's expectations, values and choices. Consideration of carers' needs were anticipated, particularly where the carer was older. Regular 'patient care reviews', involving patients and carers occurred annually or more frequently if changes occurred.

All patients over 74 years of age had a named accountable GP. Patients and carers received appropriate coordinated, multi-disciplinary care, including those living in a care home, or those returning home after hospital admission. Unplanned admissions and readmissions were regularly reviewed and improvements were made when gaps were identified.

The GPs and practice nurses were trained and competent to deliver care to older people. There was a lead GP for older people who attended training and disseminated the knowledge to the whole clinical team.

Access to services, including flexible appointment times allowed patients that rise early to access the practice using the early morning appointments.

People with long-term conditions

Patients with long-term conditions had their care individualised to meet their need this ensured their care included choices. Annual 'patient care reviews', involving patients and carers were offered.

The GPs and practice nurses were trained and competent to deliver care to the patient with a long-term condition. Each GP and practice nurse had specialist training in different conditions, for example, diabetes, asthma and hypertension. This gave them the skills to refer to specialists if required. We saw how patients were signposted to patient groups and supported to access a support network locally.

We saw that there was proactive case management and monitoring of people with long-term conditions. Access to services included flexible appointment times and same day telephone consultations, were available.

Mothers, babies, children and young people

The GPs provided generalist medical care during pregnancy. Information was available, including lifestyle advice on healthy living, which was given to prospective parents.

Summary of findings

There was a GP that led in cascading information about safeguarding children. This supported formal training the nurses and GPs received to recognise early identification of need and timely help was offered with other services. The GPs and practice nurses were knowledgeable, and had the skills and competences to recognise and respond to an acutely ill child. Practice nurses led in the primary and pre-school immunisation and health promotion advice.

Children and young people were treated in an age appropriate way and were recognised as individuals, with their preferences considered.

The working-age population and those recently retired

The practice offered appointments outside of normal working hours three times a week for patients to have access to a GP or nurse appointment. Alternatively, patients telephone appointments were available should a patient be unable to attend the practice. Monitoring of the appointments system occurred monthly and improvements were made where a lack of appointments were identified.

Patients who were working were offered a referral for treatment close to their place of work if this was more convenient for them.

People in vulnerable circumstances who may have poor access to primary care

We saw that the practice was proactive in assessing and monitoring the practice population needs, including for people in vulnerable circumstances.

Information on how to access GP services was available. Sign posting to specialist support groups including local shelters and support services for patients with learning disability was available in the waiting area of the practice. The GPs and nurses would discuss this with patients if required.

People we spoke with within this group said they felt able to access the practice's services without fear of stigma and prejudice.

People experiencing poor mental health

Patients received a flexible, individualised service that monitored their mental health needs within the practice population.

The GPs and practice nurses were trained and had the competences and knowledge to assess and respond to risk for patients experiencing poor mental health (including in suicide prevention).

Summary of findings

The practice supported patient to access emergency care and treatment when experiencing a mental health crisis. Staff recognised and made referrals for more complex mental health problems to the appropriate specialist services.

Care was tailored to patient's individual needs and circumstances, including their physical health needs. This included an annual health check for patients with serious mental health illnesses.

Summary of findings

What people who use the service say

On the day of the inspection we spoke with 13 patients and reviewed 22 comment cards, left by us for patients to complete, that had been filled in over the weeks before our inspection. Comments left were positive. Many patients wanted to express how well they felt treated and that all staff were accommodating, polite and professional at all times. Patients who used the service told us they were involved in decisions about their care and treatment and that they were treated with dignity and respect.

We spoke with staff from four local care homes that had patients registered at St James Surgery; they gave very positive feedback about the service they received.

Our conversations with patients on the day of the inspection reflected the same views as patients who had completed the comments cards. During our inspection patients told us they had a good relationship with the GPs and practice staff.

Areas for improvement

Action the service MUST take to improve

Action the service COULD take to improve

The practice could establish a system whereby it can ensure that safety alerts sent electronically to staff are acted upon in a timely way, and action taken as required.

Good practice

St. James Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, a GP and the team included a Practice Manager Specialist Advisor and an Expert by Experience. Experts by Experience are people who have experience of using care services. They take part in our inspections of health and social care services.

Background to St. James Surgery

The surgery had approximately 14,000 registered patients at the time of our inspection. The main surgery is located on two levels. The street level is accessible to people who require wheelchair access.

The main address is:

89 Wash Lane

Clacton on Sea

CO15 1DA

The branch surgery address is:

Church Square Branch Surgery

St Osyth

Clacton on Sea

CO16 8NU

The main practice is open from 8:30am to 12:30 then 1:30pm to 6.30pm Monday to Friday. Extended hours are on Monday and Tuesday 6.30pm to 7.30pm, and Thursday 7am to 8am. The branch surgery is open from 8:30am to 10:30am Monday to Friday, then Monday and Thursday 3.30pm to 6.30pm.The patients are registered at the main St James practice. Patients registered at the practice can choose to be seen at the branch surgery if that is closer or more convenient for them. The practice has opted out of providing out of hours primary medical services for its patients. Outside normal surgery hours patients are able to access emergency care from the national 111 service.

The practice employs nine GPs; seven partners and two salaried GPs. A team of five practice nurses and five health care assistants and 14 administrative staff were supported by the practice manager and a deputy.

Why we carried out this inspection

We inspected this primary care service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

Detailed findings

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

We carried out an announced visit on June 12, 2014 between 08am and 6pm.

During our inspection we spoke with a range of staff including; six GPs, five nurses, the practice manager and assistant practice manager, secretaries, administrative assistants and receptionists.

We also spoke with patients who used the service. We observed how people were being cared for and reviewed personal care or treatment records of patients.

Are services safe?

Summary of findings

The service provided was safe.

The people using the service, those close to them and staff were protected from avoidable harm. Patients we spoke with said they felt safe. Safety was a priority. Staff took an active role in delivering and promoting safety. The practice understood risks, had a clear picture of safety and was focused on improvement. The practice had a track record on safety performance that showed on-going improvement. Concerns were dealt with quickly and effectively.

Systems, processes and standard operating procedures promoted safe care, were reliable and reflected relevant guidelines. This included the approach to infection prevention and control; the building layout, cleanliness and maintenance of facilities; use and maintenance of equipment; medicines management; records management and staff recruitment checks.

Staffing levels were set and reviewed to keep people safe and meet their needs at all times the practice was open. Risks to individuals were effectively assessed and managed, including clinical and health risks and risks of harm to the patient and to others. Patients were involved and risk assessments were person-centred, proportionate and reviewed regularly.

There were emergency preparedness and incident plans in place.

Our findings

Safe Track Record

The practice had a track record on safety performance that showed ongoing improvement. Concerns were dealt with quickly and effectively. The practice manager received safety alerts from government bodies, for example the Medicines and Healthcare Products Regulatory Agency (MHRA). The MHRA is responsible for the regulation of medicines and medical devices and equipment used in healthcare and the investigation of harmful incidents. The practice responded to safety alerts which were disseminated by email to all of the staff. All the staff we spoke with about this confirmed they received patient alerts and that the system was effective. For example, we saw that a change had been made to the prescribing regime for patients on a specific medication, following a MHRA alert.

The practice had a range of meetings to discuss patient care. These were both whole practice, and specific clinical meetings that were held on a weekly basis. This ensured staff could share information and discuss any aspect of patient care to make sure patients were cared for safely.

We spoke with 18 patients and reviewed 20 comment cards that had been completed prior to and during our inspection. Patients told us they felt safe and confident in the service they received.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. When things went wrong the practice was open and transparent, incidents were investigated, learning was communicated and action was taken to improve. We saw evidence of how they carried out the investigations and the practice manager told us how the actions and recommendations were discussed at meetings. We saw evidence of this in the meeting minutes.

Significant events were recorded, investigated and discussed at a variety of practice meetings. We saw that action plans were developed to ensure the practice changed their systems where necessary to promote patient safety. However, we noted these action plans were not always reviewed. This could lead to a risk that the practice might not be aware if actions had been carried out, or if the actions had achieved the planned objectives. We drew this to the attention of the practice on the day of the inspection

and the practice acknowledged that the system required a final review to ensure that learning from incidents was robust. The practice told us they would amend their system of reviewing significant events to ensure they could check actions had been taken and that the aims of the action plan had been met. All the staff we spoke with about significant events told us that incidents, investigations and learning were shared with the staff team to ensure the practice learnt from incidents to improve outcomes for patients.

Reliable safety systems and processes including safeguarding

We were shown how the systems, processes and standard operating procedures promoted safe care, were reliable and met relevant guidelines. This included the approach to infection prevention and control; building layout, cleanliness and maintenance of facilities; use and maintenance of equipment; medicines management; records management; and staff recruitment checks. These were regularly reviewed and improvements were made when identified.

Children and vulnerable adults were protected from the risk of abuse because the practice had taken reasonable steps to identify and prevent abuse from happening. The GPs and practice nurses were trained appropriately in safeguarding and there was evidence that the practice took part in local Clinical Commissioning Group (CCG) audits of safeguarding referrals. We saw minutes of practice meetings that showed us safeguarding issues were discussed regularly. The practice had a safeguarding policy and this included the contact details of the local authority safeguarding team. We spoke with four members of the practice administrative staff. They told us they had received training in safeguarding and were able to demonstrate an understanding of the various types of abuse they could encounter during the course of their duties. There was evidence that online safeguarding training courses had been taken by administrative staff and that they took part in seminars organised by the GPs on this topic.

Monitoring Safety & Responding to Risk

Staffing levels were set and reviewed to keep people safe and meet their needs at all times the practice was open. The practice had a significant event and incident log which identified issues that could impact on the service being delivered. There was evidence of analysis and learning from the log. Incidents were discussed and shared with staff individually if required but this subject was covered in all staff meetings. We saw evidence of this in the minutes and it was also confirmed by the staff we spoke with. Where necessary, processes and procedures were put in place to reduce the likelihood of recurrence.

Emergency equipment and drugs were available and could be used by the trained and competent staff (including locums) who worked in the practice. We saw the practice nurse routinely monitored the expiry dates and stocks of emergency drugs and equipment; records of these checked were kept with the equipment. The staff in the practice knew the location of the oxygen equipment and automated external defibrillator.

Medicines Management

There were clearly defined systems, processes and standard operating procedures for medicines that minimised potential for error and promoted the safety of patients who used services. For example, repeat prescription requests were checked by administration staff before being provided. The GP reviewed medicines where there were discrepancies between what was requested and what was recorded on the patient's record before a prescription was issued. Additionally routine monitoring of fridge temperatures, emergency medicines and medical equipment ensured patient safety.

Cleanliness & Infection Control

A lead nurse was responsible for infection control procedures at the practice. There were appropriate policies and procedures in place to reduce the risk and spread of infection. We were told that the practice's infection control procedures were checked every six months. We saw the results of the last two checks in August 2013 and February 2014. The most recent check had highlighted the need for pedal operated clinical waste bins. These had then been put in place by the practice.

Hand washing reminders were available above all sinks both in clinical and patient areas. There was a supply of liquid soap and hand towels in all areas. Personal protective equipment (PPE) such as gloves and aprons were available for staff and they were aware of when PPE should be used. There was segregation of waste. Clinical waste was disposed of appropriately and after being removed from the practice was kept in locked waste bins to await collection.

Are services safe?

Patients we spoke with commented positively on the standard of cleanliness at the practice. The premises were visibly clean and well maintained. Work surfaces could be cleaned easily and were clutter free. There was a cleaning schedule for staff outlining the cleaning tasks that should be completed on a daily, weekly and quarterly basis. Cleaning of the premises was monitored by the practice manager.

Staffing & Recruitment

The practice had a recruitment policy that reflected the recruitment and selection processes completed by the practice. We looked at nine staff files and saw that appropriate checks had been carried out. All staff had a completed criminal records check through the Disclosure and Barring Service (DBS). The practice manager told us that checks with the General Medical Council (GMC) and to the Nursing & Midwifery Council (NMC) were routinely in place to ensure staff maintained their professional registration.

We spoke with the GPs and practice manager about staffing levels within the practice. They told us there were strategies in place for the clinical team to safely cover staff shortages and absences with minimal or no use of locum or agency staff. We were told that recent staff shortages had required the use of an agency member of staff. In order for continuity for patients the practice had tried where possible to always have the same agency member of staff.

There were sufficient staff at the practice. Patients told us they never had to wait for long periods of time, unless they had requested to see a specific GP or nurse.

Dealing with Emergencies

The practice had both an emergency and business continuity plan in place. We found that the plan included details of how patients would continue to be supported during periods of unexpected or prolonged disruption to services, for example, extreme weather that caused staff shortages and any interruptions to the facilities available.

Equipment

The facilities and equipment in use at the practice were routinely maintained and checked. Many items were for single use only and staff told us that they disposed of these items immediately after use resulting in patients being protected from the risk of infection from contaminated equipment. Equipment was appropriately stored and was secure.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service provided was effective.

Patients received care, treatment and support that achieved positive outcomes, promoted quality of life and was based on the best available evidence. National evidence-based best practice, professional standards and expert guidance were used routinely. They were appropriately tailored to meet the needs of patients who used services.

Patients' needs were assessed appropriately and care and treatment was planned and delivered in line with current legislation, standards and nationally recognised evidence based guidance. This included assessments of capacity and the promotion of good health.

There was a multi-disciplinary collaborative approach to care and treatment. There was proactive engagement with other health and social care providers and joint working arrangements in place with effective communication, information sharing and decision making about a patient's care.

Our findings

Effective needs assessment, care & treatment in line with standards

National evidence-based best practice, professional standards and expert guidance were used routinely. They were appropriately tailored to meet the needs of patients. We spoke with the GPs and nurses; they told us that patients' needs and potential risks were assessed at initial consultations with the clinicians. We were told that individual clinical and treatment plans were agreed with the patients and recorded on the computerised system. We were told by the GPs that patients received care according to national guidelines. We saw that relevant guidelines and national strategies were made available to staff.

Care and treatment consistently achieved positive outcomes for people in line with expected norms. The practice used data and information to understand and improve the quality of services. We were shown records of medicine audits that had been carried out following the receipt of national guidelines and standards provided to the practice by NHS commissioners and other stakeholders. For example, we saw that a change had been made to the prescribing regime for patients with a specific condition, following an update in best practice guidelines.

Management, monitoring and improving outcomes for people

The practice monitored the delivery of care and treatment to ensure it provided positive outcomes for patients. The practice used the Quality and Outcomes Framework (QOF) to monitor the service being provided. QOF is a voluntary programme for all GP surgeries in England that details the practice's achievements. The practice's performance is then financially rewarded annually. Overall the QOF reflected positive outcomes for patients. Two GPs we spoke with explained to us how they carried out regular audits. We saw evidence of recent audits completed for prescribing, depression and infection control. The practice followed up to check any changes made following the audit had resulted in improvements.

The practice manager informed us of a recent audit completed on the number of patients who had gone to Accident and Emergency (A&E) which could have been

Are services effective?

(for example, treatment is effective)

avoided. It was recognised that one patient needed additional support due to this audit and this was offered to them. This audit is to continue to identify trends and changes that could be made for the patients support.

Effective Staffing, equipment and facilities

We saw from records, and from information shared by staff we spoke with that there were processes in place for managing staff performance and professional development. Staff knew who was responsible for managing and mentoring them. We were shown records that confirmed all staff had completed training in Basic Life Support (BLS), information governance, infection control, confidentiality and safeguarding children and vulnerable adults. Nurses were trained according to their specialist areas. These included diabetes, asthma, family planning, travel vaccines, epilepsy, coronary heart disease, chronic obstructive pulmonary disease (a long-term respiratory disease) and updates in childhood immunisations. We were told by clinical staff that they attended external meetings and events to help further enhance their continuing professional development.

We saw from clinical staff records that they received regular training updates. We were told by all staff that they received annual appraisals and informal supervision. All the staff we spoke with felt they received the support they required to enable them to perform their roles effectively.

Working with other services

There was a multi-disciplinary collaborative approach to care and treatment. Staff worked closely with other health and social care providers, to co-ordinate care and meet patients' needs. For example, the practice regularly worked with the palliative care team to discuss the needs of patients requiring end of life care and to ensure patients care was being managed effectively. We saw minutes of meetings which evidenced this.

There was proactive engagement with other health and social care providers. Joint working arrangements were in place with effective communication, information sharing and decision making about a patient's care. Staff showed us how information from other healthcare providers, for example, discharge letters and treatment changes from the acute hospital, were dealt with. We saw there was a policy for the handling of mail. Administration staff open mail daily, date stamped as received and checked for urgency. Those identified as urgent were directly put in the GP's 'in box' which was checked three times a day by the GPs. All remaining mail was scanned and put into the patient's notes electronically.

Information from the out of hours service was received electronically. The secretaries checked this every morning and informed the relevant GP if action was required. For example, a follow up home visit for a palliative care patient would be carried out by their named GP.

Health Promotion & Prevention

We saw there were arrangements in place to support patients to live healthier lives. There was a wide range of literature on display in the waiting area for patients to read. For example, we saw literature about smoking cessation, alcohol consumption and carer's support. We also saw health promotion advice was offered on the practice website.

The practice was able to offer patients a wide range of services and clinics. We spoke with the practice nurse who was able to offer health promotion and preventative care and treatment. For example, child immunisations, blood pressure checks, cervical cancer screen and travel vaccination advice. We noted information regarding this was found on the practice's website. The GPs told us they provided annual health checks for patients with learning disabilities or those patients with HIV or AIDS. New patients were offered a 20 minute appointment with a nurse for an assessment.

Are services caring?

Summary of findings

The service provided was caring.

Feedback from patients who use the service, those who are close to them and stakeholders was positive about the way staff treated patients. Staff treated patients who use the service and those close to them with dignity and respect. Patients felt supported and well-cared for as a result,

All staff involved patients who use the service as partners in their own care and in making decisions, with support where needed, including support from advocates. Family, friends and advocates were involved as appropriate and according to the patient's wishes.

Our findings

Respect, Dignity, Compassion & Empathy

The practice had a policy for protecting patient confidentiality and a copy was on display in the waiting room. The practice displayed notices advising patients that chaperones were available. Staff told us that, in accordance with their policy, all patients who required intimate examinations were automatically offered a chaperone. This was confirmed when some of the patients we spoke with told us that they had been offered a chaperone. Staff had received training in how to chaperone whilst a clinician examined the patient.

Clinical staff told us that they always explained to patients that any procedure could be stopped at any time. Patients spoken with on the day of the inspection told us that clear explanations were given for treatments, medicines and tests. They had also been given choices and options of where they would prefer their treatment to be carried out, where available. We saw all the consulting rooms and the nurse's treatment room had privacy curtains. We saw from some of the comment cards that we had left for people to complete, that patients said they found the staff were very caring and felt they were treated with dignity and respect.

Staff told us that if patients preferred to speak with them in private they were offered a private room in which to have their conversations. A member of the patient participation group (PPG) confirmed this when they told us that a separate room is available for patients who wished to speak to a receptionist in private. PPGs are groups of people who have volunteered from practice populations, to form a group for patients to work together to improve services, promote health and improve quality of care for the practice they represent. The staff we spoke with demonstrated how they considered patients' privacy and dignity during consultations and treatments, by telling us that they ensured that doors were closed and curtains were used in treatment areas to provide additional privacy.

Patients and their families received support from the practice at the time of bereavement. The GP contacted them to provide support as well as informing them about the service of a counsellor who provides a NHS clinic at the practice two mornings a week.

Are services caring?

Involvement in decisions and consent

We looked at how the practice involved patients in the care and treatment they received. We found that patient involvement in care and treatment was encouraged during the consultation and through the PPG. We were told by the patients we spoke with that they felt listened to and included in their consultations. They told us they felt involved in the decision making process in relation to their care and treatment, that GPs and nurses took the time to listen to them, and explained all treatment options available to them. They said they felt they were able to ask questions if they had any. We were told by staff that patients could see the doctor of their choice, although they acknowledged that patients sometimes had to wait a longer period of time if they wanted to see a specific GP.

The practice had procedures in place for patients to consent to treatment, and a form was used to gain the written consent of patients when undergoing specific treatments, for example, minor operations. We saw from the consent form in use, that there was space on the form to indicate where a patient's carer, parent or guardian had signed on the patient's behalf. A nurse described how they managed issues with gaining consent from patients who were unable to write. The process in place was clear and we were told by the nurse that they documented clearly the reason why written consent had not been obtained and the reason for accepting verbal consent.

We spoke with GPs about how patients who lacked capacity to make decisions and give consent to treatment were supported. They told us that mental capacity assessments were carried out by the GPs and recorded on individual patient records. All GPs were knowledgeable about how and when to make referrals and had access to the British Medical Association guidance about the Mental Capacity Act 2005. We were assured that the procedures in place ensured patients who lacked capacity were appropriately assessed and referred for example to an advocacy service where applicable.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service provided was responsive.

Patients received care which met and responded to their needs. The staff at the practice understood the different needs of the patients. Services were designed and delivered to meet those needs. This included active engagement with stakeholders to provide coordinated pathways of care.

Patients were able and supported to access the right care at the right time. Appointments systems were easy to use and supported choice. Patients waited as short a time as possible for services, treatment or care. There was an effective and proactive approach to managing referrals and appointments.

Patients were encouraged to have the information they need prior to decisions made on treatment referrals and were supported to provide feedback or make a comment or complaint about their care. Patients were listened to and treated with respect when they raised concerns; they were involved in the process and received feedback. The practice continuously reviewed and acted on feedback and complaints about the quality of care and used this information to improve services. The practice was open and honest about the learning and action they had taken.

Our findings

Responding to and meeting people's needs

People receive care which meets and is responsive to their needs. The GPs and practice nurses explained how they assessed patients' individual needs and risks during consultations. This involved a detailed history being obtained and opportunities for patients to ask questions before agreeing their treatment plans

The practice operated individual lists for each GP. Patients nearly always got to see their GP of choice because of this. The practice nurse did phone triage for patients and made a decision about who could best deal with the patient's issues to ensure they were directed to the most appropriate person.

GPs described how they discussed with individual patients and carers, which consultant to refer them to based on the patients' needs and individual preferences. GPs told us that they tended to refer patients locally, as this was what most patients preferred. However, referrals to hospitals outside the area were made if it was appropriate and requested by the patient or their carer.

We saw from records and from the information shared with us by staff, that the practice had well established links with the local area commissioners. We were told by a GP that meetings took place on a regular basis to assess, review and plan how the service could continue to meet the needs of patients and any potential demands in the future.

Access to the service

People were able and supported to access the right care at the right time. Appointments systems were easy to use and supported choice. The practice offered both pre-booked, same day and emergency appointments to patients which provided flexibility. In the event of an emergency, patients could ring on the day or request a telephone call back from the GP. On the day of the inspection it was noted that there were times still available for same day appointments. The GPs carried out home visits when required for patients who were unable to get to the surgery or receiving palliative care. Information about the out of hours GP service was noted on the practice website, the patient information leaflet and on the answer phone when the practice was closed.

Patients said they were given a 10 minute appointment slot but said they never felt rushed and could take longer if they

Are services responsive to people's needs?

(for example, to feedback?)

needed to. They told us they did sometimes have to wait for a while before they were seen but said reception staff always told them if a GP was running late and would give them an indication of how long they would have to wait.

The practice opened late until 7:45pm on two weekday evenings and early appointments were available one day a week, so that working patients could access appointments without taking time off work.

Concerns & Complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The practice complaints policy was included in the practice leaflet given to new patients.

Details of how to make a complaint, including the practice's response time were included on the practice website and a leaflet was available at the practice. Most of the patients we spoke with were aware of how to make a complaint. Staff were clear about the actions they should take and said they would give patients the complaints leaflet and refer them to the practice manager. We saw records of complaints and actions taken and were told that they used complaints to learn and improve the services provided. The practice manager told us that any clinical issues would be referred to the most appropriate GP.

Are services well-led?

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

Summary of findings

The service provided was well-led.

All staff knew their responsibilities and the limits of their authority. The leadership team communicated effectively and worked collaboratively with staff. Staff felt respected, valued and supported.

Risks to the delivery of quality care were identified, analysed and those risks mitigated systematically. Issues were minimised and action taken swiftly. A proactive approach was taken to seek a range of feedback from patients, the public and staff. Patient and staff concerns were heard and acted upon.

Our findings

Leadership & Culture

All staff were clear on the vision and values of the practice. There was an open and honest culture. Clinical, administrative and reception staff all encompassed the key concepts of compassion, dignity, respect and equality. They welcomed input from patients of the practice and acted upon feedback. Staff understood their roles and were clear about the boundaries of their abilities.

Staff we spoke with said they felt very valued. They knew who to go to with any issues or concerns they may have. They said they were listened to and they felt included in decisions about the quality of the service provided.

Governance Arrangements

We looked at the governance arrangements in place at the practice and saw that these included the delegation of responsibilities to named GPs, for example, a lead for safeguarding, prescribing and minor surgery. We saw that the lead roles provided structure for staff in knowing who to approach for support and clinical guidance when required. Practice staff were clear about what decisions they were required to make, knew what they were responsible for and were very clear about the limits of their authority.

Clear and effective arrangements were in place to monitor and improve the quality of the services provided to patients, minimise risk to patients and staff, engage and support staff and ensure the sustainability of high quality care. For example complaints were discussed at the partners meeting and with reception staff where appropriate. We saw evidence of this in the minutes and this included what action was to be taken and any changes to be made to improve the service

Systems to monitor and improve quality & improvement (leadership)

We saw that the practice manager and GP partners were in a continuing process of reviewing and improving comprehensive systems for monitoring all aspects of the service. This was to maximise effective governance, plan future developments and to make improvements to the service. GPs and nurses explained how improvements were discussed at meetings and individuals were given actions to undertake within their responsibility range. For example St James practice had been identified as a high prescriber

Are services well-led?

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

of a certain antibiotic. The GP's discussed this in their meeting and had put a 'score board' in the GP's room to visually remind them and to identify who was that week's highest prescriber.

We looked at the systems in place to monitor and improve the quality of service provision. We found that the performance in the Quality and Outcomes Framework (QOF) report for 2012 to 2013 showed that the practice achieved above the average for practices in England. (The QOF audits detail the GP practice achievement results.) The practice used information from QOF audits to further monitor the quality of the services provided to patients. We saw that QOF audit results fed into clinical audits. We saw that clinical audits were effective when they were completed because checks were carried out to monitor the standards and to identify risks.

We found that the GP partners and practice team staff constantly challenged existing arrangements and looked to continuously improve the service being offered. These arrangements supported the governance and quality assurance measures taken at the practice and enabled appropriately trained staff to review and improve the quality of the services provided.

Patient Experience & Involvement

A proactive approach was taken by the practice to seek a range of feedback from people who use the service, the public and staff. There was a suggestion box in the reception area for patients to give feedback. The practice manager told us they always discussed any feedback at the weekly meetings. Minutes from these meetings supported this.

The practice actively encouraged patients to be involved in shaping the service through the contribution of the patient-led patient participation group (PPG). PPGs are groups of people who have volunteered from practice populations, to form a group for patients to work together to improve services, promote health and improve quality of care for the practice they represent. The practice responded proactively to patients' comments and surveys and adopted a patient centred approach to delivering care and treatment.

Patients spoken with on the day of the inspection told us they were aware of how to make a complaint but had never felt the need to because they were happy with the service. The practice manager told us that if they were on the premises when a complaint came in they would make themselves available to discuss the issue. If a complaint came in by post the complaints procedure was followed. We saw a log of written and verbal complaints. These had all been responded to and dealt with to the satisfaction of the complainant.

Practice seeks and acts on feedback from users, public and staff

We saw that engagement with patients was managed through the patient participation group and we spoke with their representatives during the inspection. They told us that the practice was responsive to suggestions and supported regular patient surveys to consider ways to improve the practice and make changes where it was practicable to do so. We saw examples of where changes had been made in response to comments and feedback received from patients, including changes to improve the environment for patients. Patients also had the opportunity to engage with the practice through their website. This included by sending in comments or concerns by a link within the web site which was monitored by the practice manager. We saw some of the recent comments that had been received and the action that had been taken.

Staff were encouraged to attend and participate in regular staff meetings and we saw evidence that regular meetings took place to include discussions about changes to procedures, clinical practice, and staff cover arrangements. We saw that the practice openly discussed significant events at these meetings, shared their learning and explained the actions required to reduce the risk of them recurring. Staff were aware of the practice's whistleblowing policy and where to find it.

Management lead through learning & improvement

The leadership at the practice communicated effectively with the staff and the staff worked collaboratively.

There was a development plan which covered all key areas for the practice to review performance and make improvements. Staff were set individual and team objectives. The plan was managed by the practice manager and updated regularly by the senior partners in conjunction with the practice manger. Staff fed into the development through staff meetings.

The practice supported staff innovation. Staff regularly took time out to review performance and take action to improve

Are services well-led?

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

it. The practice continually looked at data provided by the local CCG in order to identify risk within the area so that they could take action to minimise any risk. This included the re-training of staff in the area of the risk identified or the employment of additional staff to cope with demand for services.

Identification & Management of Risk

A system was in place to respond to safety alerts from external sources which may have implications or risk for the practice. These included NHS England, Medicines and Healthcare Products Regulatory Agency (MHRA) and National Patient Safety Agency (NPSA). Staff were informed of the alerts via email and in meetings and they were also placed on the practice central computer storage system which provided each staff member with a reading list. There was a member of staff identified as lead for risk assessment for the practice

Staff told us they felt confident about raising any issues and felt that if incidents did occur these would be investigated and dealt with in a proportionate manner. The practice manager and senior staff monitored any potential risks and had contingency plans to deal with all eventualities.

Significant event analysis (SEA) were reviewed and learning and action points were discussed at meetings.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

Care was tailored to individual needs and circumstances, including a patient's expectations, values and choices. Consideration of carers' needs were anticipated, particularly where the carer was older. Regular 'patient care reviews', involving patients and carers occurred annually or more frequently if changes occurred.

All patients over 74 years of age had a named accountable GP. Patients and carers received appropriate coordinated, multi-disciplinary care, including those living in a care home, or those returning home after hospital admission. Unplanned admissions and readmissions were regularly reviewed and improvements were made when gaps were identified.

The GPs and practice nurses were trained and competent to deliver care to older people. There was a lead GP for older people who attended training and disseminated the knowledge to the whole clinical team.

Access to services, including flexible appointment times allowed patients that rise early to access the practice using the early morning appointments.

Our findings

The practice had arrangements in place to care for patients who are aged 75 and over.

Care was tailored to individual needs and circumstances, including a patient's expectations, values and choices. Consideration of carers' needs were anticipated, particularly where the carer was older. Regular 'patient care reviews', involving patients and carers occurred annually or more frequently if changes occurred.

The GPs were actively involved in primary and secondary care multi-disciplinary team meetings for the whole of the Clinical Commissioning Group. These meetings often discussed patients with multiple and complex needs, including people aged 75 and over. The GPs increased their knowledge about how to care for older people through engagement with a wide range of professionals.

All older patients had a named accountable GP. Patients and carers received appropriate coordinated, multi-disciplinary care, including those who were living in a care home or those returning home after hospital admission. Unplanned admissions and readmissions were regularly reviewed and improvements were made when gaps were identified.

The assistant practice manager told us that they had over 2000 patients aged 75 and over registered with the practice; included in this were 133 patients receiving care for dementia. The practice offered health checks and home visits to these patients. None of the patients we spoke with were aged 75 and over. However, computer records confirmed that patients in this population group were assessed by GPs and practice nurse, and referred as appropriate to services to help maintain independence; for example to social services.

The GPs and practice nurses were trained to deliver care to the older patients. There was a lead GP for older patients. They attended specific training and disseminated the knowledge to the whole clinical team.

Older people

Access to services, including flexible appointment times and home visits were available.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

Patients with long-term conditions had their care individualised to meet their need this ensured their care included choices. Annual 'patient care reviews', involving patients and carers were offered.

The GPs and practice nurses were trained and competent to deliver care to the patient with a long-term condition. Each GP and practice nurse had specialist training in different conditions, for example, diabetes, asthma and hypertension. This gave them the skills to refer to specialists if required. We saw how patients were signposted to patient groups and supported to access a support network locally.

We saw that there was proactive case management and monitoring of people with long-term conditions. Access to services included flexible appointment times and same day telephone consultations, were available.

Our findings

Patients with long-term conditions had their care individualised to meet their need this ensured their care included choices.. Annual 'patient care reviews', involving patients and carers were offered. The practice was sensitive to and meets the needs of patients with long-term conditions.

A patient with complex and long term conditions, who had been a long-term patient at the practice, told us that they were very happy with the treatment and care they received at the practice. They said the communication and interaction with all staff was good.

The practice identified patients with long-term conditions and targeted them for health checks and health promotion. Arrangements were in place with local chemists to deliver medication to people who were unable to get to the surgery patients.

The GPs and practice nurses were trained and competent to deliver care to patients with long-term conditions. Each GP and practice nurse had specialist training in different conditions, for example, diabetes, asthma and hypertension. Referrals to specialists were made appropriately where required. We saw how patients were sign-posted to patient groups and supported to access a support network locally. The practice liaised with and referred patients with long term conditions to district nurses, community matrons, rapid assessment team, and out of hours team. The practice offered annual flu injections to patients with long term conditions, as well as to other priority groups of patients.

We saw that there was proactive case management and monitoring of people with long-term conditions and that access to services, including flexible appointment times and same day telephone consultations were available.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

The GPs provided generalist medical care during pregnancy. Information was available, including lifestyle advice on healthy living, which was given to prospective parents.

There was a GP that led in cascading information about safeguarding children. This supported formal training the nurses and GPs received to recognise early identification of need and timely help was offered with other services. The GPs and practice nurses were knowledgeable, and had the skills and competences to recognise and respond to an acutely ill child. Practice nurses led in the primary and pre-school immunisation and health promotion advice.

Children and young people were treated in an age appropriate way and were recognised as individuals, with their preferences considered.

Our findings

The GPs provided generalist medical care during pregnancy. Information, including lifestyle advice on healthy living was available and this was given to prospective parents.

The practice provided ante-natal care in partnership with the local hospital. The practice also offered a weekly walk-in baby clinic which was run by the community health visitors. The practice was meeting national targets in relation to primary care services for children.

There was a GP that led in cascading information about safeguarding children. This supported formal training the nurses and GPs received to recognise early identification of need and timely help was offered with other services. All staff were aware of child protection and safeguarding procedures. The practice was able to demonstrate that staff had taken action when they had concerns about potential abuse and child neglect to protect them from harm. The GPs and practice nurses were knowledgeable, and had the skills and competences to recognise and respond to an acutely ill child. Practice nurses lead in the primary and pre-school immunisation programme and health promotion advice.

Children and young people were treated in an age appropriate way and were recognised as an individual, with their preferences considered. The practice did not run services specifically aimed at teenagers but the doctors were aware of the 'Gillick competency test' and used this to assess younger patients' maturity to make decisions without the consent of their parents when this was appropriate. Gillick competence is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

The practice offered appointments outside of normal working hours three times a week for patients to have access to a GP or nurse appointment. Alternatively, patients telephone appointments were available should a patient be unable to attend the practice. Monitoring of the appointments system occurred monthly and improvements were made where a lack of appointments were identified.

Patients who were working were offered a referral for treatment close to their place of work if this was more convenient for them.

Our findings

Arrangements were in place to meet the needs of working age people. For example, the practice had introduced extended surgery opening hours two evenings and one morning a week. This allowed patients who could not attend an appointment during the day because of work commitments to see a GP or nurse in the evening, or before the start of the working day. Alternatively patients that were unable to attend the practice telephone appointments were available. Monitoring of the appointments system occurred monthly and improvements were made where lack of appointments were identified.

Patients in this group were offered to be referred for treatment close to their place of work if this was more convenient for them.

A health check service was available for patients aged between 40 and 74 years to assess their health with an aim to prevent disease. The checks included lifestyle, smoking cessation and alcohol awareness advice.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

We saw that the practice was proactive in assessing and monitoring the practice population needs, including for people in vulnerable circumstances.

Information on how to access GP services was available. Sign posting to specialist support groups including local shelters and support services for patients with learning disability was available in the waiting area of the practice. The GPs and nurses would discuss this with patients if required.

People we spoke with within this group said they felt able to access the practice's services without fear of stigma and prejudice.

Our findings

We saw that the practice was proactive in assessing and monitoring the needs, of people in vulnerable circumstances. Information on how to access GP services was made available to these groups. Sign posting to specialist support groups was available in the waiting area, and the GPs and nurses would discuss this with patients if required. People we spoke with said they felt able to access the practice's services without fear of stigma and prejudice.

The practice had arrangements in place for patients in vulnerable circumstances. These included patients who misuse alcohol, patients who are victims of domestic abuse and patients with learning disabilities. On the day of the inspection the assistant practice manager informed us 89 patients were on their register of people with learning disabilities.

The practice reviewed, identified and invited patients that would benefit from a health check or health promotion advice. Patients on the learning disabilities register were offered two 30 minute slots a year for a full medical check-up. Appointment times in-between these were also extended. The first was with a practice nurse and the second was with the GP. This was to allow time for the patient to talk with staff at their pace and not be rushed.

For other patients, the practice liaised with and referred them to local community or hospital based services as appropriate. We saw evidence of referrals to domestic violence and drug and alcohol services.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

Patients received a flexible, individualised service that monitored their mental health needs within the practice population.

The GPs and practice nurses were trained and had the competences and knowledge to assess and respond to risk for patients experiencing poor mental health (including in suicide prevention). The practice supported patient to access emergency care and treatment when experiencing a mental health crisis. Staff recognised and made referrals for more complex mental health problems to the appropriate specialist services.

Care was tailored to patient's individual needs and circumstances, including their physical health needs. This included an annual health check for patients with serious mental health illnesses.

Our findings

Patients received a flexible, individualised service that monitored their mental health needs within the practice population. The practice had arrangements in place for patients experiencing poor mental health. They liaised with and referred patients to local community psychiatric services and early intervention teams. These included urgent and routine referrals as necessary. We saw that where local health teams had made treatment recommendation that these were followed. These included MIND Counselling and Community Psychiatric Nurses.

The GPs and practice nurses were trained to assess and respond to risk for patients experiencing poor mental health (including in suicide prevention). This included supporting people to access emergency care and treatment when experiencing a mental health crisis; and recognising and managing referrals of patients with more complex mental health problems to the appropriate specialist services. GPs took the lead in mental health at this practice. They were actively involved in Clinical Commissioning Group wide primary and secondary care multi-disciplinary team meetings. Cases were presented by local GPs at these meetings for shared learning and decisions made about care and support for patients and carers.

In exceptional circumstances and where necessary, patients were referred for Consultant Psychiatric assessment. We saw evidence of some of these referrals.