St James Medical Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St James Medical Practice on 10 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for all population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available on the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

The overall rating for St James Medical Practice is 'Good'.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. 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 easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

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

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

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 chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people 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. There were systems in place 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 A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

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

People whose circumstances may make them vulnerable

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 including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff 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)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 90% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with five patients from different age groups, who had varying levels of contact and had been registered with the practice for different lengths of time.

The patients we spoke with were very complimentary about the services they received at the practice. For example, the overall friendliness of the staff, their caring nature and desire to help was mentioned. All patients said the doctors and nurses were extremely competent and knowledgeable about their treatment needs. They said that the service was good and that their views were valued by the staff.

Patients reported that staff treated them with dignity and respect. They always allowed them time and they did not feel rushed. We reviewed 28 CQC comment cards which had been completed by patients prior to our inspection. All were complimentary about the practice, the staff who worked there and the quality of service and care provided. There were no negative comments recorded.

The latest National GP Patient Survey completed in 2014 showed the large majority of patients were satisfied with the services the practice offered. The results were amongst the best when compared with GP practices nationally. The results were:

• 96% had confidence and trust in the last GP they saw or spoke to

• 94% say the last nurse they saw or spoke to was good at giving them enough time

• 91% describe their overall experience of this surgery as good

The PPG also undertook their own survey of the practice in February 2014. Again there were very positive comments regarding patient's access and care, with 92% of respondents stating that the care they received was good or better.

Areas for improvement

St James Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team was lead by a CQC inspector. A GP Specialist Advisor also took part in the inspection.

Background to St James Medical Practice

The practice is located in a large building in King's Lynn. On the day of our inspection the patient list was approximately 16,500 which was weighted to 18,300 due to covering an area of high deprivation and an above average number of elderly patients.

The practice is within the area covered by West Norfolk Clinical Commissioning Group. The practice has opted out of the requirement to provide GP services outside of normal hours. The out-of-hours service is provided by the East of England Ambulance Service.

The practice had ten GP partners and employs two whole time equivalent salaried GPs. The practice also employ six practice nurses and four healthcare assistants / phlebotomists as well as administrative staff.

The practice is registered with the Care Quality Commission to provide the regulated activities of; the treatment of disease, disorder and injury; diagnostic and screening procedures; family planning; maternity and midwifery services and surgical procedures. The practice offered a range of clinics such as, diabetes, anti-coagulation, asthma, COPD, family planning and epilepsy.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

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

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

Detailed findings

Before visiting, we reviewed a range of information that we hold about the practice.

We carried out an announced visit on 10 February 2015. During our visit we spoke with a range of staff including GPs, a nurse, healthcare assistant, reception and administration staff. We spoke with patients who used the service. We observed the interactions between patients and staff, and talked with carers and family members.

We reviewed 28 CQC comment cards where patients had shared their views and experiences of the service.

In advance of our inspection we talked to the local clinical commissioning group (CCG) and the NHS England local area team about the practice. We also reviewed information we had received from Healthwatch, NHS Choices and other publically accessible information.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety, identified risks and improved patient safety through a variety of means. Reported incidents, national patient safety alerts, comments and complaints received from patients as well as other guidance were used by the practice. Staff we spoke with were aware that they should raise concerns, knew how to report incidents and near misses as well as who they should report to. Clinical governance meetings took place on a quarterly basis. If any clinical governance issues needed to be discussed at other times, then these were discussed at partner meetings.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The significant events log was examined for incidents since January 2014 and we saw this system was followed appropriately. Six significant events had been recorded and investigated in this time period. Although significant events were not a standing item on the practice meeting agenda, they were always included when identified. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Significant events were investigated and learning identified in a timely manner. Staff, including receptionists, administrators and nursing staff, knew how to request areas for discussion at the meetings and they felt encouraged to do so.

Staff used incident forms and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents and the book where incidents were recorded. We looked at three incidents and saw records were completed in a comprehensive and timely manner. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the practice to practice staff via email. Staff could then access the information on the practice computers to update themselves. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Triangles and blue icons were used to identify vulnerable children and adults on patient records. We looked at training records which showed that almost all staff had received specific training on safeguarding. Non clinical staff had received level 1 safeguarding training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. Staff were aware of their responsibilities and knew how to share information, record safeguarding concerns and how to contact the appropriate agencies in working hours and out of normal hours.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. All of the GPs within the practice were up to date on their level 3 safeguarding training and refresher courses were due later in the year.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Alerts were placed on the system if a child was on the child protection register or if they had previously been on the register. Although there was not the facility on the computer system used to place alerts for vulnerable adults, the practice placed a note on the front of a patient's electronic record so that the information was known.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms, although not on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient

and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Administrative staff would act as a chaperone if nursing staff were not available. Administrative staff had also undertaken training and understood their responsibilities when acting as chaperones, however there was uncertainty regarding where to stand during the examination. Staff receive chaperone training from the Clinical Commissioning Group (CCG).

We saw there was a system in place to follow up children who persistently failed to attend appointments. A member of staff had lists come through every month for children who required immunisations. If a child had been identified as being a non-attender, then letters and text messages were sent in advance to remind them of the appointment.

We saw that there was a system in place for reviewing repeat medications for patients with co-morbidities/ multiple medications. Annual medication reviews were carried out. If people did not attend medication reviews they were notified. Prescriptions were changed to fortnightly rather than monthly until a review had taken place. A nurse would carry out annual reviews with patients with long term conditions and spoke with a GP if needed for further advice.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice had higher than average prescribing for hypnotic drugs. This was due to a weekly clinic for drug dependent patients. The practice were in the process of conducting an audit of their prescribing.

There was a system in place for the management of high risk medicines such as methotrexate, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. This was checked by the GP Specialist Advisor on the day of the inspection.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They carried out regular audits of the prescribing of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. Controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. We found that entries in the controlled drugs register were only signed by one person, whereas best practice is that two people sign. Two signatures would ensure that the possibilities of errors were reduced.

Cleanliness and infection control

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

The clinical manager was the lead for infection control and had undertaken further training to enable them to

provide advice on the practice infection control policy and carry out staff training. All staff received training about infection control specific to their role and received annual updates. We saw evidence that audits were carried out and that improvements identified for action were completed on time. Infection Control audit work was commissioned through the Norfolk and Norwich University Hospitals Foundation Trust and a further audit was due to be carried out later in the month.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. These were last updated in November 2014. There was also a policy for needle stick injury.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records that indicated the practice last had a legionella check in June 2012. The person responsible for this was in the process of organising a further legionella check, although the policy was for this assessment to take place every two years.

Equipment

Staff we spoke with told us they had enough equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was April 2014. A schedule of testing was in place.

Staffing and recruitment

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

We saw there was a rota system, or 'opposites' in place for the GPs so that there was always appropriate cover. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were enough staff to ensure that patients' needs were met and there were always enough staff on duty to keep patients safe. Weekly meetings also took place to discuss staffing issues.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. The practice employed a maintenance staff member and there was a system in place where issues were reported and then repairs were carried out.

Although there was a health and safety policy in place, the risk log was still in development and had not been implemented.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that the practice had learned from this appropriately.

Good

Are services safe?

Emergency medicines were accessible to staff in a clinical room of the practice and all staff knew of their location. The duty nurse held the key to the locked trolley the emergency medicines were kept in. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. The plan was being updated as new software had been installed and amendments were required.

Fire safety checks of equipment and exits were carried out either weekly or fortnightly. Fire drills were being carried out regularly, the last one recorded was December 2014. Fire equipment had been formally checked by an external company in July 2014. The practice had also carried out lone working audits for staff who may fall into this category.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager how NICE guidance was received into the practice. They told us this was downloaded from the website and sent to staff via email. We saw minutes of clinical meetings which showed NICE guidance was discussed and any required actions were agreed.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. Staff explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Clinicians we spoke with had identified issues relating to the referral of diabetes patients to podiatry services. This was a local policy problem within the area and was being discussed with the CCG.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us a number of clinical audits that had been undertaken in the last year. Examples included audits in prescribing, joint injections and consent for minor surgery.

The practice was aware of all the areas where performance was not in line with national or CCG figures and we were updated in relation to them. for example, figures show that the practice has a higher prescribing rate for hypnotics.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

The practice's prescribing rates were higher than national figures when prescribing hypnotics. This was accepted by the practice, however they ran a clinic for drug dependent patients which increased the prescribing of hypnotics. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed

Good

Are services effective?

(for example, treatment is effective)

by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register 38 patients on palliative care and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also kept a register of patients identified as being at high risk of admission to hospital and those patients were assessed and care plans drawn up and issued to them.

Effective staffing

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

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made 100% of referrals last year through the Choose and Book. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice has also signed up to the

Good

Are services effective?

(for example, treatment is effective)

electronic Summary Care Record and this is fully implemented, with new requests coming in regularly. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. An audit of consent for minor procedures was being carried out.

Health promotion and prevention

The practice offered NHS Health Checks to all its patients aged 40-75. Practice data showed that 423 out of 7045 of patients in this age group took up the offer of the health check. We were shown how patients were followed up within if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and 47% of patients (not including children) had received an annual physical health check since April 2014. The practice had identified that the problem was actually getting the patients to attend for these health checks and was working with both social services and learning disability services to increase attendance rates. The practice anticipated that six more health checks were likely to take place before the end of March 2015.

The practice had also identified the smoking status of 4025 of patients over the age of 16. Patients seeking access to stop smoking services are referred to the community services health trainer and seen in the practice. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice had carried out cervical screening for 618 patients in the previous 12 months. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example, 98% of flu vaccinations had been carried out of 3370 patients who were eligible. This was above the national average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey from 2014 and a PPG survey that was conducted in February 2014. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients as 91% rated the practice as good or very good. 92% of respondents in the PPG survey rated the practice as good or better as well. The practice was also above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 96% had confidence and trust in the last GP they saw or spoke to.
- 90% say the last GP they saw or spoke to was good at giving them enough time
- 91% say the last GP they saw or spoke to was good at explaining tests and treatments
- 97% had confidence and trust in the last nurse they saw or spoke to

Patients completed CQC comment cards to tell us what they thought about the practice. We received 32 completed cards and with the exception of one were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. The one comment card that was not positive could not be used as evidence due to the lack of anything substantial recorded. We also spoke with patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk in another room. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. It was acknowledged by the practice that the system was not ideal due to the premises being a listed building and there being limited changes that could be made. The practice had carried out some structural changes to alleviate the issue of confidentiality at the reception desk.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 91% say the last GP they saw or spoke to was good at explaining tests and treatments
- 84% say the last GP they saw or spoke to was good at involving them in decisions about their care

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and

Good

Are services caring?

supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

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

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population .

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG).

Tackling inequity and promoting equality

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of people with disabilities. There were clinical rooms on two floors, with a lift to upstairs for people with disabilities. Upstairs corridors are narrower than downstairs but patients have a choice as to where they are seen. Automatic opening doors were situated at the entrance. This made movement around the practice easier and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

The practice would register people whose circumstances may make them vulnerable such as those who were homeless or travellers. They would be registered as either patients or temporary patients, so that they could access care and treatment if required.

Access to the service

Appointments were available from 7.30am until 6.30pm, Monday to Friday. These consisted of 16 appointments as a minimum plus 3 telephone per session for each GP. Blood appointments and health care assistant appointments were available from 7.30am until 6pm. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes on a specific day each week, by a named GP and to those patients who needed one. Home visits are carried out between 9.30am and 6.30pm. The practice also employed an emergency care practitioner who carried out home visits.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Appointments were available outside of school hours for children and young people and the premises was suitable for children and young people.

An online booking system was available and easy to use. There was a text message reminder for appointments and test results and telephone consultations where appropriate.

Listening and learning from concerns and complaints

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information was available to help patients understand the complaints system . Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at five complaints received in the last 12 months and found that the practice had recorded, investigated and responded appropriately to all complaints. We saw that complaints were discussed at appropriate meetings and lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and business plan. A strategy day had been held on 1 February 2015, which involved all of the GPs and some other staff. An external facilitator had been brought in for the day. This was the start of a process that would continue and also involve the management. A number of decisions had been made at the day, including an agreement on a new build for the practice, a GP partner having more administrative time for QOF and also a discussion surrounding sacrificing profit share in order to implement other services. We saw documentary evidence of this day.

We saw that the practice had submitted a joint bid with another health centre to the Prime Minister's Challenge Fund. The joint bid was also to work in conjunction with the accident and emergency department at the Queen Elizabeth Hospital to enable the practices to open 7.30am to 8pm Monday to Friday and 10am until 4pm on a Saturday and Sunday. The bid was to offer dedicated appointments that would be directly bookable by A&E in an effort to address admission avoidance and educate patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 11 of these policies and procedures. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead member of staff for infection control and a GP partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

Leadership, openness and transparency

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

The practice manager was responsible for human resource policies and procedures. We were shown the staff handbook that was issued to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys as well as compliments and complaints. We looked at the results of the annual patient survey and saw that improvements had been made to the reception area following concerns raised.

The practice had an active patient participation group (PPG). The PPG had carried out annual surveys and met bi-monthly. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website, in addition to the minutes from the PPG meetings.

The practice had a whistleblowing policy which was available to all staff.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they were able to access relevant training when available.

Are services well-led?

Good

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

The practice had completed reviews of significant events and other incidents and shared with staff at meetings.