# St James Medical Centre

## 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 Centre on 9 December 2015. Overall the practice is rated as good.

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

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Most information about safety was recorded, monitored, appropriately reviewed and addressed. However, we saw evidence that this process was not robust to record all incidents.
- 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.
- Most 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. However, some comment cards and patients we spoke with also told us that they found it difficult to get an appointment at times.
- 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.

We saw one area of outstanding practice:

The the practice offered a model of integrated care in the community for patients with diseases of the urinary tract. This service was accessible for all patients registered with the corporate provider as well as other patients within the community. This reduced referral to hospital by 65% as patients were managed more effectively in the community.

The areas where the provider should make improvement are:

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- Ensure all incidents are recorded to ensure learning.
- Formal spot checks should be in place to ensure effective cleaning.
- All staff should be aware of all business continuity procedures
- Efforts should be made to register all carers and to ensure relevant information is available for them so that this group can access further help when required.
- Ensure an appropriate system are in place to respond to complaints timely.

**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. There was a system in place for reporting and recording significant events. However, this was not robust to record all incidents. Lessons were shared to make sure action was taken to improve safety in the practice. The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse. Risks to patients were assessed and well managed.

**Are services effective?**

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were generally above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. NICE produce and issue clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and any further training needs had been identified and planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams to improve outcomes for patients.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We saw a nurse apologise to a patient when running late demonstrating respect. The reception opened into the waiting area and we saw reception staff were caring towards patients and maintained confidentiality as far as applicable. Data showed that patients rated the practice higher than others for several aspects of care.

**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 Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. For example, it was providing an enhanced service holding a regular consultant led diabetes clinic at the practice as the prevalence of diabetes within the practice population was higher than local and

# Summary of findings

national averages. The practice also held a consultant led urology service at the practice to manage patients within the community. This reduced the hospital admission rates for the condition as patients were better managed within the community.

Feedback through comment cards suggested that some patients found it difficult to access appointments. This was also confirmed by our discussion with patients. However, the practice had recently introduced a telephone triage service as a result for those patients that were unable to get an appointment. This also allowed clinicians to prioritise these patients if they needed to be seen Urgent appointments were available the same day.. Information about how to complain was available and easy to understand. Learning from complaints was shared with staff and other stakeholders. However, evidence showed that the practice did not always acknowledge complaints in a timely manner.

**Are services well-led?**

Good

The practice is rated as good for being well-led. There was a clear corporate vision and strategy to deliver integrated care and the some of the services offered reflected this. There was a clear central corporate leadership structure to help support the practice and staff. This was further supported by clinical and administration leadership in the practice. 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 a patient participation group (PPG) and responded to feedback from patients about ways that improvements could be made to the services offered. 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. The practice had carried out reviews of patents over the age of 75 who were taking eight or more medicines.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. The practice nurse and the advanced nurse practitioner had lead roles in chronic disease management. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All patients diagnosed with a long term condition had a named GP and a structured annual review to check that their health and medicine needs were being met. For those patients with the most complex needs, the clinicians worked with relevant health and care professionals to deliver a multidisciplinary package of care. This included specialist clinics for complex patients with diabetes as well as services for those disorders of the urinary system.

The GP had an interest in urology and the practice offered an integrated care in the community model service for patients with diseases of the urinary tract. This service was available for all patients in the community and not just for patients registered with the practice or the corporate provider. Data we looked at showed that as a result of the service there was a 65% reduction in referral to hospital as patients were managed effectively in the community.

**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 and regular multidisciplinary team meeting with the health visitors. The practice ran baby clinics with immunisations. Appointments were available outside of school hours and children were given appointments as a priority. The premises were suitable for children and babies and could be accessed by parents with pushchairs.

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**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 offered online services and telephone consultations as well as a full range of health promotion and screening that reflected the needs of this age group. For example, the provider had developed a smart phone application where patients could use to make appointments, order repeat prescriptions, access self-help guides as well as provide real time feedback.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients with learning disability and offered annual health checks. There was a flexible approach to the way appointments were offered with longer appointments for people with a learning disability. Vulnerable patients were discussed at regular practice meetings as well as monthly multidisciplinary meetings. 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)**

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). We saw that there were 52 patients on the mental health register and the practice carried out annual physical health checks for these patients. Double appointments were available for those with complex needs and the practice regularly worked with multidisciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice utilised local services for counselling support. Patients were also signposted to a variety of groups and voluntary organisations for self-referral. Those with more complex mental health needs were referred into the local community mental health services. There was 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.

# Summary of findings

## What people who use the service say

The national GP patient survey results published on 8 July 2015 showed the practice was generally performing better than local and national averages. Of the 451 survey forms that were were distributed, 66 were returned representing a completion rate of 15%.

- 73% found it easy to get through to this surgery by phone compared to a CCG average of 63% and a national average of 73%.
- 88% found the receptionists at this surgery helpful (CCG average 82%, national average 87%).
- 74% were able to get an appointment to see or speak to someone the last time they tried (CCG average 77%, national average 85%).
- 94% said the last appointment they got was convenient (CCG average 89%, national average 92%).
- 74% described their experience of making an appointment as good (CCG average 64%, national average 73%).
- 70% usually waited 15 minutes or less after their appointment time to be seen (CCG average 54%, national average 65%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 41 comment cards which were all positive about the standard of care received. Patients described a good service and staff who were caring, helpful and respectful. However, 10 comments cards whilst positive about the sevice also commented on the difficulty of accessing routine appointments.

We spoke with four patients and a carer during the inspection. Most patients said that they were happy with the care they received and thought that staff were approachable, committed and caring. However, one patient stated that they also foind it difficult to get an appointment all the time. They also commented that as all the GPs worked part time they found it difficult to see the GP of their choice at a time that was suitable for them.

## Areas for improvement

**Action the service SHOULD take to improve**

- Ensure all incidents are recorded to ensure learning.
- Formal spot checks should be in place to ensure effective cleaning.
- All staff should be aware of all business continuity procedures
- Efforts should be made to register all carers and to ensure relevant information is available for them so that this group can access further help when required.
- Ensure an appropriate system are in place to respond to complaints timely.

## Outstanding practice

We saw one area of outstanding practice:

The the practice offered a model of integrated care in the community for patients with diseases of the urinary tract. This service was accessible for all patients registered with the corporate provider as well as other patients within the community. This reduced referral to hospital by 65% as patients were managed more effectively in the community.

# St James Medical Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector**.** The team also included a GP specialist advisor.

## Background to St James Medical Centre

St James Medical Centre provides primary medical services to approximately 3600 patients in the local community. The practice is part of a corporate partnership and four salatied GPs (two male and two female) worked part time at the practice. The GPs are supported by an advanced nurse practitioner (ANP), a practice nurse and one health care assistant. The non-clinical team consists of an administrative and reception staff and an acting deputy practice manager. The acting deputy practice manager was new to the role and is being supported by a practice manager from a nearby location that was part of the corporate partnership.

The practice has a General Medical Services contract (GMS) with NHS England. A GMS contract ensures practices provide essential services for people who are sick as well as, for example, chronic disease management and end of life care. The practice also provides some directed enhanced services such as minor surgery, childhood vaccination and immunisation schemes. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract.

The practice opening times are 8.30am to 6.30pm Monday to Friday with the exception of Thursdays when the practice closes at 1pm and does not re-open during the afternoon. The practice provides an extended hours service on Tuesdays when it is open from 6.30pm to 7.30pm.

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by the external out of hours service provider when the practice is closed including Thursdays when the practice closed for the afternoon.

Home visits are available for patients who are unable to attend the practice for appointments. There is also an online service which allows patients to order repeat prescriptions and book new appointments without having to phone the practice. The corporate provider has developed a smart phone application for making appointments and requesting repeat prescriptions as well as to provide feedback of their experience.

The practice treats patients of all ages and provides a range of medical services. This includes specialist consultant led clinic to manage complex cases for diabetes. The practice also provides an integrated care model for urology services at the practice that is consultant led from a local hospital.

## Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal

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

## How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 9 December 2015.

During our visit we spoke with a range of staff including the acting deputy practice manager, a practice manager from another location that was part of the corporate provider and who was helping to acting deputy practice manager as they were new to their role. We spoke with the advanced nurse practitioner (ANP), practice nurse, the healthcare assistant (HCA) as well as two Gs including the lead GP. We also spoke with members of the administration team and the governance and quality manager for the corporate partnership

Observed how people were being cared for and talked with patients and carers. We reviewed comment cards where patients shared their views and experiences of the service.

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

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

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

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

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

Good

# Are services safe?

## Our findings

### Safe track record and learning

There was an effective system in place for reporting and recording significant events. The practice had recorded five significant events over the last year. For example, one event related to a verbally aggressive patient. We saw that this was recorded and shared using an electronic system with the Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. Minutes of meeting showed that this incident was discussed along with the practice zero tolerance policy. The policy also contained advice on how to deal with aggressive patients.

Another event recorded in showed that the practice had failed to close the shutters when all staff had left for a training event. The incident was reviewed and risks such as to data security were identified. The practice responded by developing a checklist for closing up of the practice at the end of surgery.

Although the practice was recording and sharing learning from incidents and significant events we were not confident that all incidents were being documented to improve practice. We spoke with a patient who told us about an event where they were given the wrong information and as a result, were unhappy with the practice and had made this known. We spoke with staff members who confirmed that this incident had taken place but had not been recorded as an incident or complaint.

### Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse, which included arrangements to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements. Policies were accessible to all staff and clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The lead GP was the responsible member of staff for safeguarding and all staff we spoke with were aware of this. All staff including the lead GP had attended training to an appropriate level. We saw that the lead GP had recognised a potential safeguarding issue through a significant event and had taken appropriate action.

A notice in the waiting room and in the consultation rooms advised patients that chaperones were available, if required. All staff who acted as chaperones were trained for the role. Most staff members had received a disclosure and barring (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). A staff member we spoke with told us that if a staff member had not undergone a DBS check then they would never be left alone with a patient. However, we were told by management that this had changed and only staff that that had undergone DBS checks would carry out the duty of a chaperone. Also, the practice was in the process of undertaking DBS checks for all administration staff.

The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The advanced nurse practitioner (ANP) was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. The ANP showed us an infection prevention pack they had prepared containing information such as the practice infection control policy, disposable instrument policy, needle stick injury protocol, Control of Substances Hazardous to Health (COSHH) data sheets as well as other relevant information. We saw these packs were in every consultation room we looked into and staff members we spoke with confirmed they used these packs where appropriate.

We saw infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The practice employed an external cleaner with a daily, weekly, monthly and quarterly cleaning schedule. There was an activity sheet to show that the cleaner had followed the schedule but these were not dated and so was not auditable. The acting deputy practice manager confirmed that they visually checked if schedule was being followed by the cleaner but this was not formalised.

There were arrangements in place for managing medicines, including emergency medicines and vaccinations and the ANP and the practice nurse were responsible for this. We checked medicines for use in a medical emergency and those being kept in refrigerators. We found medicines were

Good

# Are services safe?

stored securely, in date and were only accessible to authorised staff. Records showed that fridge temperature checks were carried out which ensured medicines were stored at the appropriate temperature.

We reviewed four personnel files and found 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 DBS checks were in place for these staff members.

**Monitoring risks to patients**

Risks to patients were assessed and well managed as there were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and carried out regular fire drills. All the practice staff had received training as part of the in house protected learning time (PLT) event from the centralisation manager who had experience in this area from their previous role.

All electrical equipment was checked to ensure all equipments were safe to use and clinical equipments were checked to ensure it was working properly. We saw evidence that the practice had instructed an external specialist to carry out a legionella risk assessment on 4 December 2015. However, whilst the risk assessment was carried out the practice was awaiting the report at the time of the inspection. This would identify actions, if any the practice may need undertake to protect patients from the risk of legionella.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. For example there were four regular salaried GPs who worked specific days and times along with other staff members including nursing and administration staff.

**Arrangements to deal with emergencies and major incidents**

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

All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use. We were told about a recent emergency event at the practice where a staff member had recognised that a patient needed immediate attention after they had walked into the surgery. The practice staff had followed appropriate procedures and the patient had received emergency medicines and treatment before being transferred to the local hospital.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. However, some of the staff we spoke with aware of the business continuity plans.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had access to guidelines from NICE available on the practice computer network and used this information to develop how care and treatment was delivered to meet needs. The lead clinician we spoke with confirmed to us that they had access to NICE guidelines. The practice had four salried GPs with a lead GP. The practice was part of a GP organisation that operated across 13 different locations in Sandwell and Birmingham and we saw evidence that the use of NICE guidance was monitored centrally by relavant lead GPs within the partnership.

The practice had systems in place to identify and assess patients who were at high risk of admission to hospital. This included reviewing discharge summaries following hospital admission to establish the reason for admission. These patients were reviewed to ensure care plans were documented in their records and their needs were being met which assisted in reducing the need for them to go into hospital.

Practice data showed that they had completed medicines review of all patients aged over 75 years and over who were on eight or more medicines.. This group of patients also had a named GP to ensure good continuity of care.

**Management, monitoring and improving outcomes for people**

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the total achievement for QOF was 99.8% of the total number of points available, with 8.8% exception reporting. The QOF includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed;

Performance for diabetes related indicators was better compared to the CCG and national average. The practice achievement for diabetes indicators was 100[KT1]%[RA2], this was 7.8% better than local CCG and 5.5% above national average.

The percentage of patients with hypertension having regular blood pressure tests was better compared to the CCG and national average. The practice achievement was 86.9% which was 4.8% better than the CCG and 3.3% better than national average.

Performance for mental health related indicators was better compred to the CCG and national average. The practice achievement was 96.2% which was 7.1% better than local CCG and 3.4% above national average.

The dementia diagnosis rate was below to the CCG and national average. The practice percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was 80%. This was 4.3% below the local CCG and 4% below national average. The practice prevalence rate for dementia was slightly lower than local and national averages.

The practice had completed a number of clinical audits with evidence to confirm that these were positively influencing and improving practice and outcomes for patients. We saw evidence of completed audits where improvements were implemented and monitored. For example, the practice had conducted an antibiotic audit in November 2014 with action points. A re-audit was carried out in February 2015 which identified that improvements had been made. It also identified actions for further improvements. The practice had also conducted audits on patients taking nutritional supplements with re-audits showing improvements in the monitoring of patients including requesting of input from other professionals such as dieticians where appropriate.

Staff had the skills, knowledge and experience to deliver effective care and treatment. There was an established team which included four part time salaried GPs. The team also included an advanced nurse practitioner (ANP), a practice nurse and one health care assistant. The non-clinical team consisted of an administrative/ reception staff and a deputy acting practice manager. The acting deputy practice manager was being assisted by another practice manager from a nearby practice that was part of

Good

# Are services effective?

## (for example, treatment is effective)

the corporate partnership. The acting deputy practice manager was also being assisted by other staff such as the Quality and Governance manager from the central management team.

The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. We spoke with a new member of staff who confirmed that they had been through the induction programme and were still receiving support from the managers and clinicians when requested.

The practice had a training matrix and could demonstrate how they ensured role-specific training and updats for relevant staff such those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme.

The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Training was delivered externally as well as internally though eLearning and in house Protected Learning Time (PLT) events.

Staff received training that included safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of eLearning training modules and in-house training.

**Coordinating patient care and information sharing**

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system, their intranet and an integrated pathology and discharge summaries system linked to the local acute hospital. This included care plans, risk assessments, medical records and results of tests and investigations. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a regular basis and that care plans were routinely reviewed and updated.

The practice also received governance data pack from the central management team from the corporate partnership. The data pack was RAG (Red, Amber and Green) rated with actions. These allowed the practice to further monitor and improve patient outcomes.

**Consent to care and treatment**

Patients' consent to care and treatment was sought in line with legislation and guidance. Booklets were made available to all staff on the principles of the Mental Capacity Act 2005. Our discussion with staff demonstrated that they understood the relevant consent and decision-making requirements of legislation when providing care and treatment and would act on any concerns about a person lacking capacity to consent. This included Gillick competence (the Gillick test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). Staff confirmed that assessments of capacity to consent would be carried out in line with relevant guidance. The lead GP we spoke with also confirmed that they had completed eLearning in consent..

There were 19 patients on the learning disability register and 52 patients on the mental health register. We saw that this was monitored by the central management team to ensure all had received an appropriate health review. We reviewed a sample of care plans for patients with a learning disability and those with mental health needs and saw that they were supported to make decisions through the use of care plans, which they were involved in agreeing.

**Health promotion and prevention**

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition, those requiring advice on their diet, smoking cessation and sexual health advice.

Most of the patients registered at the practice were of south Asian heritage and as a result the prevalence rate for diabetes was higher than the national average. As a response the practice provided an enhanced service to

Good

# Are services effective?

## (for example, treatment is effective)

provide a specialist clinic at the practice. This was an integrated care model in the community delivered by a diabetes consultant from the local hospital for patients with more complex needs.

The practice had an electronic screen with health promotion information such as the benefits of exercise. There was also posters and practice leaflets with details of services for patients to access including a range of self-referral service such as sexual health, smoking cessation and mental health services.

The practice had a comprehensive screening programme. Data showed that the practice's uptake for the cervical screening test over the last five years was 81.4% which was 6% above the CCG average and in line with the national average. There was a system in place to recall and follow up patients who did not attend for their cervical screening test. Findings were audited to ensure good practice was being followed.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending the practice, at the reception desk and on the telephone. We saw people were treated with dignity and respect. For example, we saw that the practice nurse had come out of their consulting room on two separate occasions to apologise to a patient because they were running late.

Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We received 41 CQC comment cards from patients prior to the inspection. Of those 31 comments cards were positive in regards to the service experienced. Patients said staff were helpful, caring and respectful. All the comment cards highlighted that staff responded compassionately when they needed help and provided support when required. We also spoke with four patients including one member of the Patient Participation Group (PPG) on the day of our inspection. All the patients told us that they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

- 92% said the GP was good at listening to them compared to the CCG average of 84% and national average of 89%.
- 85% said the GP gave them enough time (CCG average 82%, national average 89%).
- 93% said they had confidence and trust in the last GP they saw (CCG average 92%, national average 95%)
- 85% said the last GP they spoke to was good at treating them with care and concern (CCG average 80, national average 85%).
- 92% said the last nurse they spoke to was good at treating them with care and concern (CCG average 87%, national average 90%).
- 88% said they found the receptionists at the practice helpful (CCG average 82%, national average 87%)

**Care planning and involvement in decisions about care and treatment**

Patients told us that they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

- 93% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 86%.
- 87% said the last GP they saw was good at involving them in decisions about their care (CCG average 76% , national average 81%)

We were told that 50% of the patient population were Asian and the GPs and some administration staff were able to speak most of the languages spoken by this patient group. Staff told us that translation services were available for other patients who did not have English as a first language and those they could not communicate with.

**Patient and carer support to cope emotionally with care and treatment**

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The electronic screen in the reception area also informed patients of some of the groups available for patients.

The practice's computer system alerted GPs if a patient was also a carer. We spoke with a patient at the practice who had arrived with their carer. The carer confirmed that they had been registered as a carer by the practice. In total the practice had identified 19 patients from the practice list as carers. This was below 1% of the practice population. We did not see any information that was available to direct

Good

# Are services caring?

carers to the various avenues of support available to them in the practice notices in the reception area. A carer we spoke said that they had not been given any information of support available to them should they need it[KT1]. [RA2]

We spoke with the lead clinician who told us that they had completed communication training which allowed them to respond more effectively to patient suffering with grief following bereavement. They also told us that they would provide personalised care for relatives with referral to other agencies where appropriate.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The practice worked with the local Clinical Commissioning Group (CCG) to plan services and to improve outcomes for patients in the area. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. For example, the practice provided minor surgical procedures to patients in the practice as well as an integrated care for patients with diabetes. The advanced nurse practitioner had also attended a specialist diploma course.

We saw evidence issued by the CCG to confirm that the practice had met prescribing targets set by the CCG to ensure cost effective prescribing.

The GP had an interest in urology and the practice offered an integrated care in the community for patients with diseases of the urinary tract. This was a service that was being offered by the corporate partnership for all patients registered with the corporate provider. However, other patients within the community could also be referred by their GP. We saw that 132 patients had attended this clinic over the last year with only 33 patients being referred to hospital. Out of the 33 patients that were referred to hospital only 11 patients needed surgical intervention. This represented a 65% reduction for referral to hospital as patients were managed effectively in the community.

The practice offered extended hours on a Tuesday until 7.30pm for working patients who could not attend during normal opening hours. There were longer appointments available for people with a learning disability. Home visits were available for older patients / patients who would benefit from these. Same day appointments were available for children and those with serious medical conditions.

We spoke with a patient who used a wheelchair and their carer. They told us that there was a ramp to access the practice and they had no problems accessing the service using a wheel chair. We spoke with the management staff and they told us that they were considering changing the front door to hands-free automated doors to further improve access to the building.

For patients with mental health needs the practice utilised local services for counselling support. It also signposted patients to a variety of groups and voluntary organisations for self referral. Patienst with more complex mental health needs were referred into the local community mental health services.

**Access to the service**

The practice was open between 8.30pm and 6.30 Monday to Friday except Thursdays when it closed at 1pm. Extended hours surgeries were offered on Tuesdays until 7.30pm. Patients had access to the corporate providers 'health hub' through a smart phone application. This application allowed patients to arrange same day phone appointment and to book routine appointments. It also provided information on out of hours services as well as allowing patients the ability to provide feedback[RA1]. [KT2]

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was generally better compared to local and national averages. Most patients we spoke with on the day told us that they were able to get appointments when they needed them..

- 84% of patients were satisfied with the practice's opening hours compared to the CCG average of 72% and national average of 75%.
- 73% patients said they could get through easily to the surgery by phone (CCG average 63%, national average 73%).
- 74% patients described their experience of making an appointment as good (CCG average 64%, national average 73%.
- 70% patients said they usually waited 15 minutes or less after their appointment time (CCG average 54%, national average 65%).

We received 41 comments cards and feedback from ten comment cards suggested that patients could not access care when needed. Sas a response from feddback from staff and patients, the practice had recently introduced a telephone triage system when there were no appointments available. Patients could leave their contact details for the GP to call back for assessment. If the GP felt that they needed to be seen patients were invited to attend the surgery.

**Listening and learning from concerns and complaints**

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

The practice had a policy in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The acting deputy practice manager received and responded to all complaints. The responsibility for investigating the complaint was the lead clinician. We saw that information was available to help patients understand the complaints system and staff we spoke with knew the process to follow when a patient wanted to make a complaint. The practice investigated complaints and discussed learning through staff meetings.

We saw that the practice had received five complaints for 2015. We looked closely at three complaints. We saw that one complaint was made regarding lack of access to appointments. We saw that the practice had not responded to the omplaint timely as per its complaints policy. We were told this was due to the lack of arrangmemt in place to manage the complaints process in the absence of the named lead.

# 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 was part of a corporate provider and its vision was to develop a range of integrated services in primary care. We saw that the urology services being provided at the practice was part of this vision.

**Governance arrangements**

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. The operational management team for the corporate provider met biweekly to discuss issues affecting all the practices. This team included practice managers, the governance and quality manager from the providers central operations team as well as other members from the same team.

The practice had a comprehensive understanding of the performance of the practice because the corporate provider team released a RAG (red, amber and green) rated comprehensive data quality action plan with areas for improvement. This allowed the practice to focus on areas of weakness.

There was a clear staffing structure within the practice with a lead GP responsible for clinical issues and they were supported by the advanced nurse practitioner (ANP). Clinical staff were further supported by the corporate clinical management group. The acting deputy practice manager was responsible for the day to day running of the practice and they had recently been promoted.

**Leadership, openness and transparency**

The practice had a capable and experienced corporate team for support in delivering a service to meet the needs of its patient population. The lead GP and the ANP were responsible for delivering a clinical leadership and management whilst the acting deputy practice manager was being helped to develop in their role to deliver the day to day management of the practice.

Staff told us, and records we looked at showed that regular team meetings were held. Staff also told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings. Staff said they were confident in raising any issues and felt supported if they did. There were protected learning events held in house every six monthly as well as those held by the Clinical Commissioning Group (CCG) to support staff learning and development. Clinical and administration staff from the corporate partnership attended separate events held in different locations so that learning could be tailored and shared.

Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice and this was encouraged so that opportunities for improvement could be identified.

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

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

It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. We spoke with a patient who was a PPG member on the day of the inspection and they told us that the practice listened to any suggestions made by the PPG. The PPG fed back issues related to timing of repeat prescriptions and appointment availability as well as issues in regards to phlebotomy (blood taking) service. The practice had revised its policy in regards to repeat prescription and staff had attended an update course on phlebotomy. The practice also analysed and responded to patient feedback from other sources such as NHS choices as well as the friends and family test.

Staff members we spoke with also told us that they were able to provide feedback to improve service. For example, one staff member we spoke with told us that they used to advise patients to attend the nearest walk in centre if no appointments were available. However, they fed back that there should be a triage system implemented so that patients that needed immediate attention could be seen by a GP at the practice. As a result the practice introduced an 'unmet needs' systems where patients contact details were taken and the GP would call them to discuss their needs and prioritise based on that need. This had been started recently.

**Continuous improvement**

The lead GP worked in a local hospital once a week under a urology consultant which allowed them to learn and gain

# Are services well-led?

Good

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

the knowledge and expertise to offer the urology service at the practice. The lead GP also told us that they had attended a training event as part of their own interest on evidence-based teamwork system to optimise patient care by improving communication and teamwork skills among health care professionals. They told us they were trying to implement these in the practice.