Jolly Medical Centre

Quality Report

72 Crescent Road
Crumpsall
Manchester
M8 9NT
Tel: 01617400524
Website: www.thejollymedicalcentre.co.uk

Date of inspection visit: 9 June 2015
Date of publication: 09/07/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Jolly Medical Practice on 9 June 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 to patients.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice was actively involved in local and national initiatives to enhance the care offered to patients.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered after considering 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. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients
- The practice had a clear vision that had improvement of service quality and safety as its top priority. High standards were promoted and there was good evidence of team working.

We saw several areas of outstanding practice including:

Summary of findings

- A comprehensive locum pack which contained processes and paperwork used by the practice. This was available complete with copies of forms to be used for referral to other services and key contact numbers for practice member's and other services that may be required.
- An electronic pad for recording friends and family feedback was available to the patients in the waiting room.
- An electrocardiogram service was linked directly to a clinician for instantly reporting on ECG's taken within the practice. An ECG records the electrical activity of the heart.
- The practice had achieved 100% of children vaccinated in the childhood immunisation programme despite the challenges presented by a culturally diverse population where English was not the first language for many patients.
- Awareness of staff to signpost patients to alternative and supportive services for those patients who may experience long delays in their referral to other NHS services fin particular Mental Health support for teenagers.

In addition the provider should;

- Ensure team meetings are scheduled throughout the year to ensure staff are fully aware of changes at the practice.
- Ensure the practice nurse is fully involved in clinical and professional meetings within the Clinical Commissioning Group and practice to ensure she is up to date with changes in professional practice.

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 report incidents and near misses. The practice used every opportunity to learn from internal and external incidents to help them improve. Information about safety was highly valued and was used to promote learning and improvement. Risks to patients and within the practice were assessed and well managed. There were enough staff to keep people safe. All equipment was regularly maintained to ensure it was safe to use.

Are services effective?

Good

The practice is rated as good for providing effective services. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. People's individual needs were assessed. Care was planned and delivered in line with legislation and the promotion of good health. Staff had received training and support. Effective multidisciplinary working was in place. There were effective working arrangements with community services and patient outcomes were carefully monitored. We found evidence of annual appraisal of all staff and development plans were formatted during this process.

Are services caring?

Good

The practice is rated as good for providing caring services.Patients we spoke with and those who completed the CQC comment cards were very complimentary about the service. They said all the staff (from receptionists to doctors) were kind, considerate and helpful. They told us they were treated with dignity and respect. We observed a patient-centred culture and found strong evidence that staff were motivated and provided kind and compassionate care. Staff we spoke with were aware of the importance of providing patients with privacy and of confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. The practice had made changes to the telephone system based on feedback from patients and a period of research. Patients could arrange appointments with the GP of their choice and could expect to see a GP on the day they telephoned the practice for urgent appointments and within three days for routine

Summary of findings

appointments. Appointments with a female doctor were available within her next three working days. There was a clear complaints system with evidence demonstrating that the practice responded to issues raised. Information about how to complain was available and easy to understand. Despite the limitations of the building (the building was two converted residential houses) the practice facilities were used effectively and it was well equipped to treat patients and meet their needs.

Are services well-led?

Good

The practice is rated as good for providing well-led services. 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 manage all 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 was acted upon. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and training.

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. From the practice list size of 3143 patients 188 patients were aged 65 and over, this equated to 6% of the practice population. The practice offered a named GP for those patients who were 75 years and older in line with the GP contracting arrangement. The practice had a system for ensuring elderly patients requiring urgent care were seen on the same day. Systems were in place to support those giving care to older people. The practice had a register of patients who needed care and support at the end of their lives and took part in meetings with other professionals involved in their care.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The practice had effective assessment, care planning and recall arrangements for patients with long term conditions. The practice nurse and GPs had lead roles for the management of patients with long term conditions and the practice had identified patients at risk of unplanned hospital admissions. They had identified the 2% of patients registered with the practice who were at the highest risk and had developed written care plans for those patients. Those patients and others with long term conditions had annual reviews of their health and medicines. Longer appointments or home visits were arranged for these according to individual need.

Families, children and young people

Outstanding

The practice is rated as outstanding for the care of families, children and young people. Staff demonstrated a good understanding and were proactive in safeguarding and protecting children from the risk of harm or abuse. The practice had a clear means of identifying in records those children (together with their parents and siblings) who were subject to a child protection plan and who were in looked after conditions. The practice had appropriate child protection policies in place to support staff and staff were trained to a level relevant to their role. Immunisation clinics for babies and young children were available on a weekly basis. The midwives carried out a clinic in the practice on Tuesday for pregnant ladies these clinics were supported a GP for any addition needs the ladies may encounter. Appointments both routine and urgent were available outside school hours and the premises were suitable for children and babies. Children needing urgent appointments were seen as soon as possible at the surgery. Children and young people were treated in an age appropriate way and recognised as individuals. The

population of under 18 year olds (0-18 years) accounted for 51.8% of the practice patient population which is higher than both the Clinical Commissioning Group (CCG) and the national averages for this age group (36.2% and 31.9%) . 24% of these were aged between 14-18 years of age compared with CCG averages at 20% and nationally 14.7%.The practice had achieved 100% of children vaccinated in the childhood immunisation programme despite the challenges presented by a culturally diverse population where English was not the first language for many patients.

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 reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of people living in vulnerable circumstances. The practice had a learning disability (LD) register and all patients with learning disabilities were invited to attend for an annual health check. Longer appointments were available for this and the practice used information in suitable formats to help them explain information to patients. Staff told us that the practice did not have any homeless people or traveller families currently registered at the practice. Staff at the practice worked with other professionals to help ensure people living in difficult circumstances had opportunities to receive the care, support and treatment they needed. The staff team were aware of their responsibilities regarding information sharing and dealing with safeguarding concerns. Patients attending the practice who were assessed by the GP as requiring an electrocardiogram (ECG records the electrical activity of the heart) was able to have this test and wait for the report in one visit to the practice. The practice offered a service which was linked directly to an external ECG clinician for instant reporting on those taken and results were shared with patients in real time to stop them worrying unnecessarily about the results.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice

Summary of findings

held a register of people experiencing poor mental health and invited them to attend for an annual health check. Longer appointments were arranged for this and patients were seen by the GP they preferred. The annual reviews took into account patients' employment, home circumstances and support networks in addition to their physical health. At the time of the inspection the practice had 23 patients on its Mental Health register.

The practice had a counsellor who attended weekly, patients were referred and seen within the practice so that they would be comfortable discussing any issues within a familiar environment. The practice had identified patients who required dementia screening and added alerts to the patients' medical records so clinicians were aware an assessment is required. The practice currently had 7 patients on the dementia register; currently 86% of these patients have had an annual review.

Due to pressures within the local Child and Adolescent Mental Health Service team the practice were experiencing delays in appointment times for referred young patients to this service. The practice secretary had researched charity organisations that could support both the young person and their family whilst they waited for their appointments. These details were made available to patients and relatives in a bid to ensure they were supported effectively until their appointment came through.

Summary of findings

What people who use the service say

During our visit, we spoke to seven patients and one patients who was a member of the patient participation group (PPG). A member of the practice's patient participation group (PPG) told us that they felt the practice listened to them.

We received eight completed CQC comment cards; all praised the practice, referring to staff, care and treatment. They told us staff were helpful, caring, and compassionate and that they were always treated well with dignity and respect. Patients told us they considered that the environment was clean and hygienic.

Patients had confidence in the staff and the GPs who cared for and treated them. The results of the National GP Patient Survey published in January 2015 demonstrated they performed well with 74.4% of respondents who described their overall experience of this surgery as good and 74.9% of respondents who said the last GP they saw or spoke to was good at involving them in decisions about their care (CCG 72.5% national 74.6%). 45.6% of respondents with a preferred GP said they usually got to see or speak to that GP (49.6% CCG & 53.5% national). These percentages were in line with the average results for the local Clinical Commissioning Group (CCG) and national data available.

The practice had analysed the results of the returned Friends and Family Test questionnaires for January 2015. (The Friends and Family Test is a NHS England initiative that provides patients with the opportunity to feedback on their experience). The comments from these questionnaires were analysed and the outcome reviewed and shared at team meetings. Actions to improve the service were identified. Patients were encouraged to complete friends and family feedback and had an electronic note pad installed within the waiting room for this purpose.

Areas for improvement

Action the service SHOULD take to improve

- Ensure team meetings are scheduled throughout the year to ensure staff are fully aware of changes at the practice.
- Ensure the practice nurse is fully involved in clinical and professional meetings within the Clinical Commissioning Group and the practice to ensure she is up to date with changes in professional practice.

Outstanding practice

- A comprehensive locum pack which contained processes and paperwork required to appropriately address continuing and referral needs of patients. This was available complete with copies of forms to be used for referral to other services and key contact numbers for practice member's and other services that may be required.
- An electronic pad for recording friends and family feedback was available to the patients in the waiting room.
- An electrocardiogram service was linked directly to a clinician for reporting instantly on EEC's taken within the practice. An ECG records the electrical activity of the heart.
- The practice had achieved 100% of children vaccinated in the childhood immunisation programme despite the challenges presented by a culturally diverse population where English was not the first language for many patients.
- Awareness of staff to signpost patients to alternative and supportive services for those patients who may experience long delays in their referral to other NHS services fin particular Mental Health support for teenagers whilst awaiting referral to child health and mental health services.

Jolly 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 included another CQC inspector, a GP and a specialist advisor who was a practice manager.

Background to Jolly Medical Centre

The Jolly Medical Practice is located in a residential area of Crumpsall North Manchester. The service is near to the local NHS trust and has a close working relationship with the Trust. It is part of the NHS North Manchester Clinical Commissioning Group (CCG.) Services are provided under a general medical service (GMS) contract with NHS England. There are 3143 registered patients.

Dr Jolly the registered manager had received an MBE from the Queen for services to Medicine and Health Care in the local Community.

The practice population includes a lower number (8.8%) of people over the age of 65, and a higher number (51.8%) of people under the age of 18, in comparison with the national average of 30.6% and 36.2% respectively. The practice also has a lower percentage of patients who have caring responsibilities (12%) than both the national England average (18.4%) and the CCG average (17.1%).

Information published by Public Health England, rates the level of deprivation within the practice population group as two on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice telephone lines opens from 9am to 6 pm Monday to Fridays except Wednesday when they close at 1pm. Appointments are offered between 9am and 6pm every day except Wednesday when they close at 1pm. They also held seasonal Flu vaccination clinics at certain times of the year. Patients requiring a GP outside of normal working hours are advised to contact an external out of hour's service provider GoToDoc. The practice also had access to one appointment per day after 6pm including any time at weekends and bank holidays at a local Primary Care Centre, this appointment could be used for an urgent or routine appointment. This appointment was allocated to a patient following consultation with the GP.

The practice has two GP partners, both male and a regular female locum for one session per week. The locum GP was available as required for additional sessions and they covered all GP holidays and sickness. One practice nurse, a practice manager, reception and administration staff supported the GPs within the practice.

On-line services include appointment booking and ordering repeat prescriptions.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and to look at the overall quality of the service to provide a rating for the service under the Care Act 2014.

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

Detailed findings

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. 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 living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

Before visiting the practice, we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice manager provided before the inspection.. We carried out an announced inspection on 9 June 2015.

We spoke with a range of staff including two GPs, one practice nurses, reception staff and the practice manager. We sought views from patients and representatives of the patient participation group, looked at comment cards, and reviewed survey information.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. This included investigating reported incidents, checking national patient safety alerts and sharing comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. North Manchester Clinical Commission Group had shared with us prior to the inspection that the practice had not submitted any data to them through their electronic reporting system. When we discussed this with the practice we found this was due a technical error with access to the system. This had now been resolved and the practice was entering data retrospectively. The data we looked at indicated that the practice had a good track record for maintaining patient safety.

We reviewed safety records and incident reports. The practice manager and GPs investigated and reported on the incidents and events. Interviews with staff confirmed that incidents were appropriately reported and where improvements and actions were required these were responded to appropriately. Staff told us that they felt confident to report adverse events and incidents. Staff identified a recent event they had reported and confirmed they had been given feedback following the event even though there was no action from the incident.

Minutes of meetings provided clear evidence that incidents, events and complaints were discussed and where appropriate actions and protocols were identified to minimise re-occurrence of the incident or complaint. Records were available that showed the practice had consistently reviewed and responded to significant events, incidents and complaints and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

We reviewed records of significant events that had occurred during the previous 12 months. Significant events were reviewed and discussed at the practice's monthly clinical meeting and where appropriate at reception team meetings. We saw from these records the practice discussed all patient deaths which occurred in hospital at their clinical meetings and recorded them on a data base which assisted them to ensure their electronic records were updated to reflect the death. This ensured no communication for this patient was inadvertently sent to the family causing undue distress.

Non-clinical staff meetings were about to be restarted on a regular basis after a period of ad-hoc meetings. Staff told us during the time these meetings had not been formally held communication had been good with the manager and they felt they were kept up to date with changes.

Staff told us they reflected daily on their practice and critically looked at what they did to see if any improvements could be made. For example reception staff explained had to change what they did during the day to assist with the individual needs of patients.

National patient safety alerts were disseminated by the practice manager to relevant staff. Staff confirmed they received these by email. We saw the practice manager kept a record of all alerts and any actions the practice had taken for future reference.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records that showed that all staff had received relevant role specific training on safeguarding. This training was due to be updated and the practice manager had just sourced electronic training for this purpose. We asked members of medical, nursing and administrative staff about their understanding of abuse and their responsibilities when they suspected a patient was at risk of abuse. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. A GP we spoke with provided us with an example where they had referred a patient to the local hospital and children's safeguarding team with a suspected non-accidental injury. All staff had access to the practice policy and procedure for safeguarding children and adults. They knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

The practice had one GP as the lead for safeguarding vulnerable adults and a separate GP for children. The adult lead had received training to level 3 as required to fulfil this

role and the other GP had a date to access his training. All staff we spoke with were aware who the leads were and who to speak with in the practice if they had a safeguarding concern.

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

There was a chaperone policy, which was visible in the patient waiting room. A chaperone is a person who acts as support and a safeguard and witness for a patient and health care professional during a medical examination or procedure. All reception staff were trained to undertake chaperoning duties and as they spoke a variety of languages between them the most appropriate staff member at the time undertook the role. Staff we spoke with were aware of their responsibilities as chaperone and felt this role had improved their understanding of the behaviour of some patients when they are anxious. The practice tried where possible to offer a chaperone who spoke the same language as the patient they were supporting.

Medicines management

We checked medicines stored in the nurses room and fridges. We found that they were stored appropriately. There was a current policy and procedures in place for medicines management including cold storage of vaccinations and other medicines requiring this. We saw the checklist that was completed daily to ensure the fridge remained at a safe temperature and staff could tell us of the procedure in place for action to take in the event of a potential failure of the cold chain. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines. All medicines that we checked were found to be in date. However at the time of the inspection the practice did not have a supply of Benzylpenicillin available to clinicians. Benzylpenicillin is recommended by the National Institute for Health and Care Excellence (NICE), in the pre-hospital treatment of patients presenting with suspected meningitis. The practice manager once alerted to this sourced this within one hour.

GPs reviewed their prescribing practices as and when medication alerts or new guidance was received. Patient medicine reviews were undertaken on a regular basis in line with current guidance and legislation depending on the nature and stability of their condition. The practice worked with the Clinical Commission Group (CCG) medicine optimisation team to review prescribing practices in line with best practice and national guidance.

Blank handwritten prescription forms were monitored and stored securely, however prescription forms for electronic use were not monitored as effectively due to prescription numbers not being in sequential order. The practice manager discussed with us the process she was currently implementing to ensure appropriate monitoring.

Medicines for use in medical emergencies were securely stored and staff knew where these were. The practice nurse had lead responsibility for checking stocks of medicines and their expiry dates. We saw these regular checks were recorded. The practice had reviewed its need to have a defibrillator and oxygen available and following this had decided they did not need them because 999 first responders and access to emergency departments were close by.

Cleanliness and infection control.

We saw the premises were clean and tidy. There were cleaning schedules in place and cleaning records were kept by the company responsible for cleaning the practice. Regular cleaning audits were undertaken but the practice manager did not have access to these records. The practice manager assured us they checked the cleaning was adequate on a regular basis and said they would ensure they had copies of future audits for their records. Comments recorded by patients on CQC comment cards referred to the practice as being clean and comfortable.

We saw that all areas of the practice were clean and processes were in place to manage the risk of infection. We noted that all consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available, with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/consulting rooms. Couches were washable and privacy curtains in the treatment rooms were washed and changed in accordance with a planned schedule. Nursing staff who spoke with told us about the

cleaning they undertook between patient appointments to reduce the risk of cross infection. We saw there was a notice in the waiting room advising patients on the use of the hand sanitiser.

The practice lead for infection prevention and control (IPC) was new to the role, they told us of the actions they had started to undertake to monitor and improve infection control practices at the practice. These included carrying out an IPC audit and addressing the actions from this in a methodological manner. Staff we spoke with confirmed regular checks were undertaken and demonstrated a good understanding of their role in promoting good infection control practices. The practice had recently sourced an online training package that all staff planned to complete.

Procedures for the safe storage and disposal of needles and waste products were available. Staff had access to spillage kits and policies for needle stick injury and the management of specimens.

The practice had carried out a local risk assessment for the management of Legionella and carried out appropriate actions to manage this. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal).

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. Contracts were in place for annual checks of fire extinguishers and portable appliance testing (PAT). PAT testing and calibration of electrical equipment had been undertaken.

Staffing and recruitment

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 criminal records checks through the Disclosure and Barring Service (DBS).

There was a system in place to record and check professional registration of the General Medical Council (GMC) and the Nursing Midwifery Council (NMC). We saw evidence that demonstrated professional registration for clinical staff was up to date and valid.

The practice had clear lines of accountability for all aspects of care and treatment. Clinical staff had lead roles for which they were appropriately trained. The skill mix of the staff was appropriate; each person knew exactly what their role was and undertook this to a high standard. Staff were skilled and knowledgeable in their field of expertise and were able to demonstrate how they could support each other when the need arose.

Staff told us there were enough staff to maintain the smooth running of the practice. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand. The practice manager ensured that sufficient staff were on duty to deal with expected demand including home visits and chaperoning.

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. All new employees working in the building were given induction information for the building, which covered health and safety and fire safety.

There was a staff handbook available for all staff and this was supported by a health and safety, general workplace and clinical policies and procedures for staff follow.

We saw an in-depth locum file which contained copies of all referral documentation and important documents and contact numbers. This file was kept by the locum on their desk to assist as required with the care of the patients they treated during their time at the practice.

There was a fire risk assessment in place and the practice regularly had fire equipment tested. Records of fire equipment safety checks and fire drills to ensure the safety of patients, staff or visitors were available.

Arrangements to deal with emergencies and major incidents

Good

Are services safe?

Staff described how they would alert others to emergencies by use of the panic button and could also use the panic button on the computer system.

An appropriate business continuity plan was in place. This comprehensive plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice. Staff we spoke with were knowledgeable about the business continuity plan and could describe what to do in the event of a disaster or serious event occurring.

Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). This was updated annually. Emergency medicines were available in a secure area of the practice and all staff knew of their location. 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. The practice had reviewed its need to have a defibrillator available and following this had decided they did not need one because 999 first responders and access to emergency departments were close by.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All the clinicians we spoke with were familiar with, and using current best practice guidance. The staff we spoke with and evidence we reviewed, confirmed that care and treatment delivered was aimed at ensuring each patient was given support to achieve the best health outcomes for them. Each clinician confirmed that they had online access to NICE guidance.

The GPs and practice nurse had completed accredited training for checking patient's physical health and the management of various specific diseases. The GP partner told us they shared the clinical and corporate governance between them and all GPs supported the practice nurse to deliver their responsibilities in specialist clinical areas such as diabetes, chronic obstructive pulmonary disease (COPD) and asthma.

Clinical staff told us the practice was focused on learning and developing to improve outcomes for patients. Monthly clinical meeting were held and minutes recorded showed that the clinical needs of patients and the services provided by the practice were reviewed. The practice nurse said that GPs were accessible when they needed advice or support. GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of long term health conditions.

The practice had read coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the learning disability register and palliative care register.

Test results and hospital consultation letters were received into the practice either electronically or by paper. These were then scanned onto the system daily and distributed to the relevant GP for review and action as required.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and treatment. It used the Quality and Outcomes Framework (QOF) to assess its performance and undertook regular clinical audits. QOF data showed the practice (90.2%) performed in line with the local clinical commissioning group in 2013/14 (89.8%), which was slightly below the England average of 94%. Data available to us showed that the practice achieved 809.3 points out of 897 for year ending March 2014.

CCG Data indicated that the practice was below target for cervical screening. The practice was aware of this and used the standard recall system of sending out letters to remind patients they needed to make an appointment to have this test. When this failed, the practice nurse tried ringing the patient and also spoke to patients if they were in the surgery for other reasons to encourage them to have the screening. The practice nurse confirmed that they struggled to get some patients to attend and in some instances this could be attributed to the cultural mix of the patient population.

GPs told us about the clinical audits undertaken. One audit had been undertaken in line with NICE Guidelines, to review the management of practice patients registered with type 2 diabetes who's cardiovascular risk assessment indicated the use of a statin had been appropriately prescribed this. The findings indicated this medicine had not been prescribed in all cases; these patients were then called into the practice for review. A lesson learnt document was devised from the audit and shared with all clinicians following the audit. Re-audit was to be carried out later this year. The nurse had not completed any audits of her practice.

Clinical team minutes showed that outcomes from clinical audits were shared and discussed.

The practice worked with other GP practices within the CCG and participated in monthly integrated care multidisciplinary teams meetings to discuss the care and support needs of patients and their families in the local neighbourhood.

Special information notes were used to inform out of hours services of any particular needs of patients who were nearing the end of their lives.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that some training was awaiting update we were told the practice had recently sourced on line learning to assist the practice to ensure training was up to date. All staff had access to staff policies which included a range of

Good

Are services effective?

(for example, treatment is effective)

employment policies and procedures and included information on safeguarding and whistleblowing. Staff were up to date with attending mandatory courses such as annual basic life support. A training plan was in place for future training.

The practice had a comprehensive induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality.

All GPs were up to date with their yearly continuing professional development requirements and all had been revalidated or had their revalidation date scheduled. 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.

The practice nurse was able to demonstrate that they were trained and updated to fulfil the duties they performed. However information shared with us from the CCG indicated the nurse did not attend CCG practice nurse forums which offer peer support. We discussed this and found this was due to the practice nurses commitments within the practice and her working hours. We discussed this with the GP and practice manager who agreed to look at the sessions and accommodate the nurse to attend sessions in future for her personal professional development.

All staff undertook annual appraisals that identified learning needs from which action plans were documented.

The practice was a teaching practice for third year medical students. We were told that two medical students had just completed their seven week placements and we reviewed their positive feedback on their experience.

The feedback from staff we spoke with was overwhelmingly positive. Staff were enthusiastic about working at The Jolly Medical Centre. They told us patients were central to the services they provided and were clear how their contributions contributed and impacted on the care being provided.

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 both electronically and by post.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, patients on the risk register, hospital admissions and discharges and attendance at A&E. These meetings were attended by the GP and a range of health care professionals such as district nurses and social services to improve end of life care for patients living in the community.

The practice had well established working relationships with health care professional at the local NHS Trust. All patients at the practice who required blood tests attended the local NHS Trust phlebotomy drop in clinic and this had proved to be effective with results available within a short period and sent direct to the practice. Feedback from patients had been positive about this service.

Information sharing

The practice used electronic systems to communicate with other providers. They shared information with out of hour's services regarding patients with special needs. They communicated and shared information regularly between themselves, other practices and community health and social care staff at various regular meetings.

Staff meetings had been held on an ad-hoc basis in recent months but the practice manager showed us plans for clinical and non-clinical meetings to be held monthly and an all staff meeting to be held every six months.

The practice had systems in place to provide staff with the information they needed and staff told us they could access the practice manager or GPs for any questions they may have.

An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the computer system for future reference. All members of staff were trained on the system, and could demonstrate how information was shared. One GP also maintained paper based patient notes alongside the maintaining the electronic system this was his preference.

Good

Are services effective?

(for example, treatment is effective)

Where patients fail to attend hospital appointments for which the GP has referred them, once the practice receive information from the hospital they contact the patient to discuss their non-attendance and try to rebook if necessary.

Consent to care and treatment

All clinical staff (GPs and nurse) we spoke with demonstrated an awareness of the Mental Capacity Act 2005 (MCA) and their duties in respect of this. Staff we spoke with were also aware of Deprivation of Liberty Safeguards (DoLS) although they had not had training specifically in relation to this.

Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Health promotion and prevention

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, children's immunisations, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website however this was in need of update and in leaflets and posters in the waiting area about the services available. This included smoking cessation, obesity management carer support groups and travel advice.

The practice had managed to achieve 100% of children vaccinated in the childhood immunisation programme. Staff involved in this told us that within a culturally diverse population where English was predominantly not the first language they had struggled with education of their parent population in previous years but now this hard work was showing a difference.

The practice nurses held a variety of clinics including a weekly baby clinic. The midwives also carried out a weekly clinic on the premises to support pregnant ladies within the practice. The nurse carried out a variety of clinics to support patient with long term conditions but tried to address as many issues at one consultation as possible to try to assist the patient not to have to attend on multiple occasions. The practice also operated NHS health checks for patients between 40-74 years of age.

The practice used the coding of health conditions in patients' electronic records and disease registers to plan and manage services. The practice identified patients who needed on-going support with their health. The practice kept up to date disease registers for patients with long term conditions such as diabetes, asthma and chronic heart disease, which were used to arrange annual health reviews. The practice also kept registers of vulnerable patients such as those with mental health needs and learning disabilities and used these to plan annual health checks.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with were aware of the importance of providing patients with privacy and of the importance of confidentiality. The computers at reception were shielded from view for confidentiality and staff took patient phone calls where possible away from the main reception area to avoid being overheard.

Consultations took place in consulting rooms away from the main patient waiting area. All rooms had an appropriate couch for examinations and curtains to maintain privacy and dignity. We observed staff were discreet and respectful to patients.

Patients we spoke with told us they were always treated with dignity and respect.

The results of the National GP Patient Survey published in January 2015 demonstrated the practice performed slightly below when compared with the average results for the local Clinical Commissioning Group (CCG). For example 71.3% of respondents stating the last nurse they saw or spoke to was good at giving them enough time; 64.7% of respondents said the last nurse they saw or spoke to was good at explaining tests and treatments and 80% of respondents said they had confidence in the GP and 76.6% in the nurse they last saw.

The practice had analysed the results of the Friends and Family Test which could be completed electronically or handwritten in the waiting room for January 2015 and had found comments to be positive about the practice. (The Friends and Family Test is a NHS England initiative that provides patients with the opportunity to provide feedback on their experience).

The practice offered patients a chaperone prior to any examination or procedure. Information about having a chaperone was seen displayed in the reception area and all treatment and consultation rooms.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey showed that 78.4% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments and 80% said they confidence and trust in the last GP they saw or spoke to and 77.5% said the last GP they saw or spoke to was good at listening to them.

Patients we spoke with told us that health issues were discussed with them, treatments were explained, they felt listened to and they felt involved in decision making about the care and treatment they received. Patient feedback we received indicated they felt listened to and supported.

The practice participated in the avoidance of unplanned admissions scheme and ensured care plans were in place in line with CCG requirements.

Patient/carer support to cope emotionally with care and treatment

There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including information on strokes and immunisations.

The practice notice board contained details for carers on support groups and events to assist them in their caring role. The week of the inspection was carer's week in the local community and details for the activities available were posted on the notice board.

The practice told us that they contacted family members after they had been bereavement and they were offered an appointment to come into the practice for any support they may need.

Reception staff told us the waiting room quite often became a meeting place for patients to socialise with their friends especially after a family bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Regular reviews of long term conditions such as chronic heart disease, diabetes and chronic obstructive pulmonary disease were undertaken, with alerts identified on the practice system for when recalls were due.

The NHS Local Area Team and Clinical Commissioning Group (CCG) told us that the GPs engaged with them to discuss local needs and had identified service improvement plans.

The practice was pro-active in contacting patients who failed to attend vaccination and screening programmes and worked to support patients who were unable to attend the practice. For example, patients who were housebound were identified and visited at home to receive their influenza vaccinations.

Practice staff pro-actively followed up information received about vulnerable patients.

Patients were able to access appointments on the day should this be required.

Longer appointments could be made for patients such as those with long term conditions, learning disabilities or who were carers.

The practice had also implemented suggestions for improvements where possible in response to feedback from the patient. The practice manager told us the practice was proactively trying to gain feedback from patients in order to determine how to improve and meet the needs of the population it served. Patients we spoke with told us the practice manager and the GP were always open to any suggestions they made.

Due to constraints within the local Mental health service young adults who were referred by the GP to the Child and Adolescent Mental Health Services team at the local hospital, were experiencing a delay in appointment times. As a result of noting this delay, the secretary at the practice had researched and made available details of two charity organisations who assisted with adolescent mental health issues available to both the parents and children who had been referred, to offer support whilst they waited for their NHS appointment to become available. Due to the sensitive nature of this we did not discuss this with any patients but were assured by the practice team this had been well received.

At the time of the inspection the practice had 23 patients on its Mental Health register, of the 23 patients 91% of this population had a documented care plan in place, 90% had a BP reading, 95% had an alcohol status recorded, 67% had a documented smear in the last 5 years (1 patient was outstanding) and 100% of patients on Lithium therapy had had their required blood tests.

Tackling inequity and promoting equality

Action had been taken to remove barriers to accessing the services of the practice. The practice had taken into account the differing needs of people by planning and providing care and treatment service that was individualised and responsive to individual need and circumstances.

The practice had systems in place to ensure people experiencing poor mental health had received an annual physical health check. The practice took all reasonable measures to ensure high quality of mental health care was available to patients within the limitations of the local service. The practice did not at present have regular meetings with the mental health team for the area but did receive information regarding patient attendance at the local NHS Mental Health Service. The practice had a self-help service every week in the practice where the patients could be seen by a counsellor to support their on-going needs.

An interpreter service was available if required and electronic process; however we were told this was seldom used. There was also access to a signing service as the practice had one patient who communicated in this way.

Access to the service

Information about access to appointments was available via the practice information leaflet and on the practice web site. The practice operated a choice of same day appointments and those which could be booked in advance.

67.6% of respondents to the 2015 GP patient survey said that they were satisfied with the practice opening times. With 86.2% saying the practice was easy to get through to by telephone compared with CCG average of 71.4%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

From speaking with patients we were told appointments were usually on time with not too much waiting. They did also say they were confident if they needed seeing on the day they would be seen at some point.

GP appointments were provided in 10 minute slots. Where patients required longer appointments these could be booked by prior arrangement. Staff confirmed that longer appointment times were always allocated for patients with multiple long term conditions or for patients with learning difficulties and mental health issues to ensure time was appropriately spent with patients.

The GP assured us if patients once in their consultation required extra time this would be given and he would explain and apologise to subsequent patients why there had been a delay. He felt this had always been effective for the patients. 75.3% of patients felt the GP gave them enough time.

Listening and learning from concerns and complaints

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

We reviewed how the practice managed complaints within the last 12 months. Five complaints had been made by patients or families of patients. We found the practice handled and responded to complaints well. Complainants received were acknowledged and investigated and documented in a timely manner as required. Most complaints received were made in a verbal format staff suggested this was due to wide variation in the ethnic mix of patients and their skills to write in English. The practice ensured someone with the correct language skills was available to assist the patient with their complaint even if this meant practice staff ringing the patient at a later time to note their complaint.

Investigations addressed the original issues raised and action was taken to rectify problems. We saw that information was available to help patients understand the complaints system in the form of a summary leaflet and on the practice web site.

Feedback from patients had identified there was a problem with telephone access to the surgery as the surgery only had one telephone line. Staff had now managed to secure an extra line and this had eased the congestion for patients wishing to contact the practice

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had needed to make a complaint about the practice.

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 improve services to patients. Staff we spoke with were eager and enthusiastic to help develop and improve the service. Staff were able to articulate the vision and values of the practice. The practice mission statement was displayed in the waiting room.

All staff were clear on their roles and responsibilities and each strived to offer a friendly, caring good quality service that was accessible to all patients.

There was an established leadership structure with clear allocation of responsibilities amongst the GP, practice manager and the practice staff. We saw evidence that showed the GP and practice manager met with the Clinical Commissioning Group (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people. We discussed with the GP and practice manager the need for the nurse to attend CCG forum meetings for her professional and personal development this was to be addressed as soon as possible.

Governance arrangements

The practice policies and procedures to support governance arrangements, were available to all staff on the practice's computer system. The policies included a 'Health and Safety' policy and 'Infection Control' policy. All the policies were regularly reviewed and in date and staff we spoke with were aware of the contents.

There was a clear organisational and leadership structure with named members of staff in lead roles. We spoke with staff of varying roles and they were all clear about their own roles and responsibilities. They all told us there was a friendly, open culture within the practice and they felt very much part of a team. They all felt valued, well supported and knew who to go to in the practice with any concerns. They felt any concerns raised would be dealt with appropriately.

Staff we spoke with were motivated and wanted to be part of improving the service they provided.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed the practice performed in line with other practices for the local clinical commissioning group and slightly below the England average in 2013/14.

Clinical audits were undertaken by the GPs throughout the year to audit their performance and change practice as required for the benefit of patients they supported. The nurse needed to be encouraged to complete audits of her practice to ensure effective patient outcomes were able to be demonstrated.

The practice had arrangements in place for identifying and managing risks. Risk management plans were in place.

Leadership, openness and transparency

Staff had specific roles within the practice for example safeguarding and infection control. There was a practice manager who oversaw the administration supporting staff.

The practice had a protocol for whistleblowing and staff we spoke with were aware of what to do if they had to raise any concerns. The practice had identified the importance of having an open culture and staff were encouraged to report and share information in order to improve the services provided. Staff we spoke with thought the culture within the practice was open and honest.

The practice held multi-disciplinary team meetings at least quarterly but could be convened if the need arose more often that were documented. These included clinical staff who were involved in the care of their patients. Samples of records we viewed demonstrated information was exchanged about improvements to the service, practice developments and the identified learning from complaints and significant events.

General staff meetings however had been adhoc.This had now changed and a planned schedule with dates were set in the practice diary. Information was usually shared with staff on a one to one basis. Timely communication with all staff ensured they were up to date with changes at the practice and enabled them to support patients more effectively and appropriately.

Practice seeks and acts on feedback from its patients, the public and staff

Results of surveys, significant events and complaints were discussed at clinical and staff meetings. Patients told us

Are services well-led?

Good

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

that the practice was patient centred and staff were happy to have patients involved and they could express their opinions at any time to any member of staff and were confident they would be listened to.

The practice had an active patient participation group who met on a regular basis.

The practice reception staff encouraged all patients attending to complete the new Friends and Family Test as a method of gaining patients feedback. There was also a suggestions box available at reception.

Management lead through learning and improvement

The practice worked well together as a team and supported each other as required.

The GP was supported to obtain the evidence and information required for their professional appraisal and revalidation. This is the process where doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they are up to date and fit to practice.

The practice manager regularly attended the professional forum groups established by the CCG. These forums offered training and support and opportunities to share good practice. Plans were being put into place to assist the practice nurse to attend forum meetings relevant to her profession.

Nurses were also registered with the Nursing and Midwifery Council, and as part of this annual registration were required to update and maintain clinical skills and knowledge.

Staff were up to date with annual appraisals, which included looking at their performance and development needs. Staff told us appraisals were useful and provided an opportunity to share their views and opinions about the practice.

The practice had an induction programme for new staff and a rolling programme of mandatory training was in place for all staff. Staff undertook a wide range of training relevant to their role and responsibilities. Records of staff training were available in the form of certificates in the staff files we reviewed. A complete central record of training was available for all practice staff.

The practice was not a GP training practice however they supported third year medical students for their primary medical services experience. We were shown the positive feedback from students who completed their seven week placement the week before the inspection.

The practice recognised future challenges and areas for improvement. They had completed reviews of significant events, complaints and other incidents and shared the learning from these with staff at meetings to ensure the practice improved outcomes for patients.