St Paul's Practice

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

St Paul's Practice is a busy city centre practice with 14,900 patients. As part of this inspection we visited the main practice site located in St Paul's Square in Carlisle. It is registered with the Care Quality Commission to provide the following regulated activities: treatment of disease, disorder and injury; diagnostics and screening procedures; family planning; maternity and midwifery services and surgical procedures.

We carried out an announced inspection on 29 April 2014. During the inspection we spoke with patients and staff. We also reviewed four completed patient comment cards. Feedback from patients was mainly positive. They told us they were satisfied with the care and treatment they received.

We found patients were not always protected against the risk that they might receive incorrect medicines because the provider's arrangements for checking that prescriptions issued against hospital discharge and advisory letters, were inaccurate. We have set a compliance action under Regulation 10(1)(2)(c) of the Regulated Activities Regulations (2010).

Patients' care and treatment achieved good outcomes and was seen to be based on the best available evidence. Patients were seen to be treated with compassion, kindness, dignity and respect with services organised wherever possible to meet their needs.

The way the practice was managed promoted an open and fair culture which showed a commitment to providing safe patient care.

There was a strong and visible leadership team with a clear vision and purpose. Governance structures were, overall, robust and there were systems in place for managing risks.

The practice had made arrangements to provide care and treatment that was tailored to patients' individual needs and circumstances. For example, arrangements had been made to provide older patients with an accountable GP. Patients with long term conditions were provided with access to a regular patient care review which monitored their condition, provided them with on-going treatment and advice, and helped them to better manage their own condition. Arrangements had been made to safeguard children and vulnerable patients from abuse or harm, including the provision of training for practice staff. The main practice was open until 18:30pm each week day and on some week days, late surgeries were offered to help provide working age patients with easier access to appointments.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found patients were not always protected against the risk that they might receive incorrect medicines because the practice's arrangements for checking that prescriptions issued against hospital discharge and other advisory letters, were inaccurate. We have set a compliance action under Regulation 10(1)(2) of the Regulated Activities Regulations (2010). Otherwise, satisfactory arrangements had been made to protect patients' safety and well-being.

Are services effective?

Arrangements had been made to make sure services were delivered effectively. Care and treatment was being delivered in line with current published best practice, and this helped to ensure patients were supported to live a good quality life.

Are services caring?

Patients were treated with kindness, dignity and respect and their privacy was promoted. The majority of patients told us they were satisfied with the care and treatment they received from the practice. Patients were involved in planning and making decisions about their care and treatment, and where appropriate, they were supported to provide informed consent.

Are services responsive to people's needs?

The practice understood the different needs of the population it served and had made arrangements for these to be met. The practice had reviewed their access arrangements and introduced changes which had helped to improve patients' experience of using the service.

Are services well-led?

There was a strong and visible leadership team with a clear vision and purpose. Governance structures were mostly robust and there were systems in place for managing risks.

Summary of findings

What people who use the service say

Results from the 2014 in-practice survey for St Paul's Practice showed the majority of patients surveyed were satisfied with access to appointments, practice opening hours and appointment waiting times. Some of the patients we spoke to on the day of our visit told us they had experienced no difficulties accessing appointments. However, two patients told us it was sometimes difficult to get through to the practice on the telephone. Three said it was difficult to obtain an appointment in advance. A small number of patients said they sometimes waited between two and three weeks to obtain an appointment with a GP of their choice.

Most patients who used the service told us they were satisfied with the care and treatment they received from practice staff. Patients told us staff discussed their treatment choices with them and provided clear explanations in a manner they could understand. Patients also said staff respected their privacy and dignity. They told us chaperones were available if needed and confirmed they felt safe using the service. The majority of patients said their confidentiality was respected. They also said the practice was clean and hygienic.

Areas for improvement

Action the service MUST take to improve

The practice must review the processes for handling hospital discharge and advisory letters which contain important information about medicines, so that any changes that have been made to a patient's prescribed medicines are checked by a doctor.

Action the service COULD take to improve

- Take further action to improve patient access to bookable-in-advance appointments, reduce appointment waiting times and improve patients' opportunities for access to their preferred doctor;
- Develop an effective patient participation group.

Good practice

Our inspection team highlighted the following areas of good practice:

- We saw that the practice had reviewed its prescribing rates for hypnotics in 2013 and, as a result, had achieved a reduction in the numbers of patients receiving this type of medicine. The practice was also an 'outlier' in the prescribing of oral non-steroidal anti-inflammatory medicines such as Aspirin. We saw evidence that the practice was taking steps to look at clinicians' practice in this area;
- St Paul's Practice was the first practice in the Cumbria area to adopt a new multi-disciplinary approach to reviewing and meeting the needs of patients with long term conditions, based on lessons they learnt following their involvement in the 'Diabetes Year of Care' model. Medical and nursing staff reviewed and re-organised how they worked to ensure that patients with long term conditions received more co-ordinated care and treatment. This included reviewing staff's skills and competencies and providing additional training where this was needed.

St Paul's Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Inspector** and a **GP**. The team included another CQC inspector and an expert by experience. An expert by experience is somebody who has personal experience of using or caring for someone who uses a health, mental health and/or social care service.

Background to St Paul's Practice

St Paul's Practice is a busy city centre practice with 14,900 patients. The practice provides care and treatment to patients living in the Carlisle area. The practice serves an area that has a higher level of deprivation, including income deprivation affecting children and older people, and a higher number of older people aged over 65, than other practices in the local Clinical Commissioning Group (CCG) area. The practice also has a small group of patients whose first language is not English.

The practice occupies the ground floor of a block of flats and is fully accessible to patients with mobility needs. St Paul's Practice provides a range of services and clinics, including, for example, clinics for patients with asthma and epilepsy and those who need support with drugs and alcohol. The practice is made up of seven GP partners, one practice manager partner and over 40 members of staff. St Paul's Practice also operates a branch surgery at the following address:

- Arnside House
- Sycamore Lane
- Carlisle
- Cumbria

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. We carried out an announced visit on 29 April 2014. During our visit we spoke

Detailed findings

with a range of staff including: a managing GP partner who acted as the clinical governance lead for the practice; the practice manager; a GP; the practice nurse team leader; a nurse who acted as the infection control lead for the practice; the medicines manager; and some of the staff who worked in the prescriptions, reception and data entry teams. We also spoke with 11 patients who were visiting the practice on the day of our visit. We reviewed four comment cards where patients shared their views and experiences of the service with us.

Are services safe?

Summary of findings

We found patients were not always protected against the risk that they might receive incorrect medicines because the practice's arrangements for checking that prescriptions issued against hospital discharge and other advisory letters were inaccurate. We have set a compliance action under Regulation 10(1)(2)(c) of the Regulated Activities Regulations (2010). Otherwise, satisfactory arrangements had been made to protect patients' safety and well-being.

Our findings

Safe patient care and learning from incidents

Arrangements had been made to report, record and learn from safety incidents, concerns or near misses. The practice had a significant event analysis (SEA) policy which provided staff with guidance on how to report, respond to, review and learn from incidents and significant events. (SEA is a form of case-based audit which helps staff to critically analyse events which have had, or might have had, a major impact on patients and to learn from such events to prevent reoccurrence.)

We were shown a register which provided an overview of the significant events and 'near misses' that had occurred and the actions that had been taken to prevent reoccurrence. The register showed that seven significant events had occurred during the previous 12 months and these had been dealt with proactively and improvements had been made. For example, a concern was raised with the practice about the lack of continuity of care that a patient received before they were admitted into hospital. The issues raised were treated as a significant concern and handled under the practice's significant event review process. Subsequent changes were then made to the systems for carrying out home visits and allocating named doctors to improve patient care.

Safety information from a variety of sources had been used to feed into the SEA review process, such as information from complaints and feedback from patients. All of the staff we spoke with demonstrated an understanding of the importance of carrying out SEA reviews. Staff also said that considerable emphasis was placed on the importance of learning lessons so that mistakes were not repeated.

Practice meetings were used to discuss significant events and 'near misses'. We were told information about lessons learnt from SEA reviews was shared with the practice team via email, team meeting minutes and completed SEA forms stored on the practice's intranet. A culture of openness operated at all levels in the practice which encouraged the reporting of errors and 'near misses'. The local Clinical Commissioning Group (CCG) was made aware of all significant events and 'near misses' occurring within the practice.

Are services safe?

Safeguarding

The practice had systems in place for safeguarding children and vulnerable adults. They had completed the General Practice Self-assessment Safeguarding Audit and had, for the most part, recorded details of any improvements they thought were needed. This showed the practice had assessed all aspects of its safeguarding processes and systems for both children and adults to help ensure staff took robust action in response to incidents, or allegations of harm or abuse. The practice had appropriate policies and procedures which covered the safeguarding of both children and vulnerable adults. This ensured staff had clear guidance about what they must do to protect vulnerable patients.

Patients told us they felt safe using the services at St Paul's Practice. There were designated staff in the practice that had lead roles for safeguarding children and adults. This ensured there were clear lines of accountability. The staff we spoke with knew who the safeguarding practice leads were and said they knew what to do if they had concerns about a vulnerable patient's health and welfare. The practice was in the process of developing a system to help staff record any safeguarding concerns, although relevant staff were already able to access 'at a glance' information about patients considered to be at risk of harm or abuse.

Staff had completed safeguarding training. For example, all GPs had completed safeguarding training to level 3. This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns. Reception staff had completed basic awareness training. This helped to protect patients because staff had received training that was appropriate to their roles and responsibilities.

Clinical staff meetings were used to consider any 'current' child protection or adult safeguarding concerns, and to identify any action that needed to be taken and who should do this. This helped to ensure patients' welfare was safeguarded because systems were in place to enable important information to be shared and to ensure appropriate action was taken when required.

Monitoring safety and responding to risk

The practice monitored safety and responded to changes in risk to keep patients safe. For example, we were told that in early 2013, the practice's appointment system was unable to cope with the level of demand placed on it by patients requesting urgent same-day care. We were told a decision was made to review how access to appointments was managed to reduce risks to patients' health and well-being. The appointment system was reconfigured and steps taken to more closely match capacity (availability of staff with the right skills) to predicted levels of demand (requests by patients for book-on-the-day and book-in-advance appointments). This has helped to ensure patients with urgent same-day care needs were able to promptly obtain the treatment they felt they needed. The provision of additional appointments after 5pm on some weekdays provided working patients with better access outside of normal surgery opening hours.

The practice had a recovery and continuity plan which included an assessment of potential risks that could affect the day-to-day running of the practice, and provided information about contingency arrangements that staff would be expected to follow. This helped to keep patients safe and free from harm and ensure the continuity of the service in the event of an emergency.

Medicines management

Most of the evidence we obtained during the inspection indicated that the practice had systems and processes for managing medicines and protecting patients from harm. For example, we were able to confirm that relevant staff had received appropriate medicines training. Provision of appropriate training helps to reduce the risk of errors being made. A community pharmacist was attached to the practice for half a day a week. This helped to enhance the practice's risk management arrangements. A CD register was used to record information about the use of CDs. Appropriate arrangements were in place for the disposal of controlled drugs. These arrangements helped to promote the safe management of CDs and reduce risks to patient safety.

Medicines and vaccines requiring cold storage were stored appropriately and effective stock control measures were in place. Checks were carried out daily to make sure such medicines were stored at the correct temperature. These arrangements helped to ensure patients received medicines that were effective because they had been stored appropriately.

A prescriptions team of three was responsible for processing all repeat prescriptions. The practice employed a medicines manager and pharmacist to help ensure it complied with the standards set by the local clinical commissioning group (CCG). The practice web site included

information about how to obtain repeat prescriptions. Patients were able to access these by telephone, post or on-line via the practice website. None of the patients we spoke with raised any concerns about the arrangements for accessing repeat prescriptions.

Before we carried out our site visit to the practice, we were told about a recent incident involving a prescription error that could have impacted on the health and well-being of a patient. The medicines manager told us that, at times, they could be the first person to read hospital discharge and advisory letters which contained prescription directions. They also said they would write up the prescription before the GP had the opportunity to review any medicines related information contained in these letters. The staff we spoke with acknowledged this was a potential safety risk. We were concerned that the failure to have a system in place which ensured all hospital discharge and advisory letters containing prescription directions were first reviewed by a GP, placed patients at potential risk of receiving incorrectly prescribed medication. The GP clinical governance lead immediately consulted with key staff within the practice to address this concern.

Cleanliness and infection control

The practice was clean and hygienic throughout. Suitable arrangements had been made which ensured the practice was cleaned to a satisfactory standard. For example, cleaning staff signed an accountability sheet to confirm required cleaning tasks had been carried out. Staff told us that any shortfalls in the quality of cleaning were immediately addressed with cleaning staff. Protective paper covers for consultation couches, personal protective equipment and materials, and bins for clinical and sharps waste, were available in each consultation room we visited. The majority of waste bins had recently been replaced with foot operated ones to minimise the risk of hand contamination. All of the patients we spoke with told us the practice was clean and hygienic.

A thorough check of infection control arrangements had recently been carried out by the practice infection control lead. This identified areas where improvements needed to be made and the infection control lead was able to demonstrate what action they were taking to address shortfalls. Appropriate arrangements had been made for handling specimens and relevant staff had received training in this area. Appropriate infection control policies and procedures were in place. These provided staff with guidance about the standards of hygiene they were expected to follow. Training records confirmed staff had received infection control training. This was also confirmed by the staff we spoke with. This helped to ensure that effective and reliable arrangements had been made to protect patients and staff from the risk of infection.

Staffing & Recruitment:

We looked at the records of staff that had been appointed since the practice's registration in April 2013. We found that thorough checks had been undertaken to make sure clinical staff were registered with their professional body and were fit to practise. For example, checks had been carried out on recently appointed GPs to make sure they were registered with the General Medical Council and on the National Performers List. We found Disclosure and Barring Service (DBS) checks had been obtained for new staff, or that the provider had made arrangements to view a copy of an applicant's most recent DBS check, before obtaining its own disclosure. Before appointing a GP who had qualified in the European Community, the practice paid for their medical qualification and registration details to be translated into English. These checks helped to ensure only suitable staff were employed by the practice, and this promoted and safeguarded patients' welfare.

Dealing with Emergencies

Systems were in place to identify and manage foreseeable risks. The provider's business continuity plan set out the alternative arrangements that would be put in place if, for example, the practice IT system failed. The plan had recently been reviewed to make sure it was up-to-date and relevant. This meant the practice had taken steps to make sure there would be no disruption to the services provided to patients in the event of an emergency. An 'Emergency Situations Protocol' had been devised to help staff be clear about how they should respond in the event of an emergency. The practice had equipment for managing emergencies. This included medication and resuscitation equipment. The drugs available for emergency purposes were within their expiry dates which meant they were safe to use. We were told regular checks of medicine expiry dates were carried out and we found these had been documented. Staff we spoke with knew where to access the practice's resuscitation equipment and checks were completed to make sure it was kept in good working order. Staff told us they were clear about the action to take in the event of a medical emergency. All relevant staff had completed Cardio Pulmonary Resuscitation (CPR) training

during the previous 12 months. Each consultation room had a 'panic button' call system which could alert colleagues in the event of an emergency. These arrangements helped to protect patients from the risk of harm in the event of foreseeable emergencies.

Equipment

A range of equipment was available within the practice. This included medicine fridges, a defibrillator, oxygen, sharps boxes (for the safe disposal of needles), an electrocardiogram (ECG) machine and fire extinguishers. We saw regular checks of the equipment took place to ensure it was safe to use. This included, for example, the testing and calibration of medical equipment, as well as testing for the presence of legionella in practice water systems.

Are services effective?

(for example, treatment is effective)

Summary of findings

Arrangements had been made which helped to ensure services were being delivered effectively. Care and treatment was being delivered in line with current published best practice, and this helped to ensure patients were supported to live a good quality life.

Our findings

Promoting best practice

Patients' needs were assessed and their care and treatment was delivered in line with current legislation and standards. The staff we spoke with said the care and treatment they provided was evidence based and informed by relevant quality standards, such as those provided by the National Institute for Health and Care Excellence (NICE). The practice nurse team leader told us that the practice placed a lot of emphasis on learning, and that where staff identified they needed to undertake additional training, this was arranged. We confirmed that clinical staff had access to relevant national and local guidance and care pathways.

Arrangements were in place which helped to ensure informed consent was obtained for the care and treatment provided to patients. Guidance was available to clinicians about how they would seek informed consent from patients, including children, who might find it difficult to provide valid consent. A GP we spoke with told us about the steps they had taken to seek and obtain informed consent from a patient attending the substance misuse clinic they ran. They were able to show us how they had recorded the person's consent. The nurse clinicians we spoke to told us they never provided any care and treatment without first seeking the patient's permission. Patients told us they had been asked for their consent to any care and treatment they received. This helped to ensure that patients' rights to refuse care and treatment were respected.

Management, monitoring and improving outcomes for people

We found outcomes for patients who used the practice were mostly in line with expected norms. We looked at the Quality Outcomes Framework (QOF) for this practice. (The QOF is a voluntary incentive scheme for GP practices which rewards them for how well they care for patients.) The latest available performance data showed the practice had, for the most part, achieved good outcomes for its patients. This meant the practice had not only produced registers which identified patients suffering from a range of chronic diseases, such as asthma and cancer, but had also delivered healthcare interventions in line with nationally accepted clinical guidelines. The practice manager told us

Are services effective?

(for example, treatment is effective)

they were responsible for providing complete, accurate and timely performance information to enable QOF data to be submitted, and robust systems were in place to enable this to happen.

Arrangements had been made to care for patients with mental health needs, patients requiring palliative care and mother, babies and children. (Palliative care aims to alleviate pain and discomfort to improve quality of life for all patients with any end stage illness.) We saw the practice had obtained almost all of the QOF points available to them indicating they had taken steps to achieve good patient outcomes and provide good quality clinical care. For example, over 88.2% of patients on the mental health register had a comprehensive care plan in their records which had been agreed with the patient and their supporters. Advice about how to access mental health support was available on the practice web site. We were told the practice had developed strong links with, and referred patients to, a local organisation that provided mental health services, including a counselling service. Doctors and nurses from the practice ran a weekly clinic for patients with drug and alcohol problems to help them move towards recovery. The practice had identified patients in need of palliative care. Regular multidisciplinary case review meetings were held, where the needs of all patients on the palliative care register were discussed. The practice had a system to alert the out-of-hours service or practice duty doctor to patients dying at home. The practice had obtained the maximum number of points for the additional services they provided. This included providing, for example: mothers with ante-natal care and screening in line with local guidelines; women with contraceptive advice; and child development checks at intervals consistent with national guidelines and policy.

The practice carried out clinical audits leading to improvements in the quality of their clinical care. For example, one of the GPs we spoke to told us they had recently carried out a clinical audit to assess the effectiveness of a cancer test the practice carried out. We were told that this had led to improvements being made, and that a re-audit would be carried out to check that the improvements made were effective.

Intelligence information we considered as part of our planning for this inspection identified that the practice was an 'outlier' in that it had a higher rate of prescribing hypnotics than similar practices in the local clinical commissioning group. (Hypnotics are medicines that are prescribed for patients who have difficulty sleeping.) We saw that the practice had reviewed its prescribing rates for hypnotics in 2013 and as a result had achieved a reduction in the numbers of patients receiving this type of medicine despite the practice's additional services to specific patient groups. The practice was also an 'outlier' in the prescribing of oral non-steroidal anti-inflammatory medicines such as Aspirin. We saw evidence that the practice was taking steps to look at clinicians' practice in this area.

The practice had also made arrangements to monitor other aspects of the care and treatment provided to patients. For example, monthly audits were carried out to check that practice guidance about how patient information should be recorded was being followed. We were told that any discrepancies were investigated and feedback given to relevant staff.

Staffing

Staff employed to work at the practice were qualified and competent staff who had the right skills and experience to carry out their roles safely and effectively. The partnership was stable and many staff had worked at the practice for over ten years, with some having worked there considerably longer. We were told practice staffing levels were subject to constant review to ensure they remained relevant and appropriate. An additional GP had recently been recruited to help the practice respond to the demand for appointments. Clinical staff had developed special interests which helped to ensure that patients' needs could be met by practice staff. For example, regular eye and ear, nose and throat clinics were held by three of the partners who had a special interest in these areas. Other GPs at the practice had a range of specialist interests covering such areas as mental health, diabetes, women's health and GP education.

Arrangements were in place to provide staff with opportunities for continued learning, including protected time, provision of appraisals and attendance at weekly practice meetings. Revalidation of doctors was well underway and personnel files for recently recruited GPs contained evidence that annual appraisals had been completed as part of the five yearly revalidation process. (Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are

Are services effective?

(for example, treatment is effective)

up-to-date and fit to practice.) The practice had an induction programme which staff were expected to complete. A completed induction record was in place for a recently appointed GP.

Working with other services

The practice had made arrangements to promote multidisciplinary working with other services. For example, district nurses and health visitors were invited to attend practice team and other relevant meetings. We were told this helped to promote the sharing of relevant information and consensus over any action that needed to be taken regarding patient care.

Some GPs at the practice had trained as GPwSI (GP with special interests.) This meant these GPs were able to provide an extended service around treating referrals from other practices in the area with eye, ear, nose and throat problems. Patients requiring drug and alcohol support were able to access a joint weekly clinic, run in conjunction with a local secondary care provider. We were told patients were offered an initial assessment, and the opportunity to benefit from a recovery plan.

The practice had a system for transferring and acting on information about patients seen by other doctors out-of-hours, which helped to ensure patient safety. One of the partners acted as the director of the local out-of-hours co-operative and continued to work shifts for them which we were told helped to promote effective working relationships. The GP clinical governance lead represented the practice at local clinical commissioning group level enabling them to contribute to the development of healthcare services within the locality.

This meant the practice had taken steps to improve the quality of care provided to patients by contributing to the development of better collaborative working between relevant professionals, such as community nurses and secondary care specialists, i.e. hospital consultants. This has helped to provide patients with improved access to health care and treatment in the local community.

Health, promotion and prevention

Arrangements had been made to support people to live healthier lives. Health promotion work was carried out by the practice nurse team. The staff we spoke to demonstrated a commitment and dedication to achieving the best possible outcomes for their patients. Nursing staff were clear about their roles and responsibilities, and said they had skills, knowledge and competencies required to carry out health promotion and preventive care and treatment. The practice provided a range of services and clinics, and other specialist services, such as mental health, ophthalmology (eye) and dietetic clinics. Information about the services provided was available on the practice web site. Information relating to health promotion and any local initiatives that were taking place in the coming months was available in the reception area. New patients were offered a health assessment on registering with the practice which included a review of their current health and lifestyle. Children newly registered with the practice were invited to attend for an appointment with staff that had skills working with this age group. We were shown documentary evidence which confirmed this was happening in practice.

Are services caring?

Summary of findings

Patients were treated with kindness, dignity and respect and their privacy was promoted. The majority of patients told us they were satisfied with the care and treatment they received from the practice. Patients were involved in planning and making decisions about their care and treatment, and where appropriate, they were supported to provide informed consent.

Our findings

Respect, dignity, compassion and empathy

Patients were treated with kindness, dignity and respect. This was confirmed by all of the patients we spoke with.

We saw that all consultations took place in private with the doors to consultation rooms being closed during patient-doctor consultations. Privacy curtains were available in all the consultation rooms. A separate room close to the reception area was available should a patient indicate they wished to speak confidentially about a private matter.

Reception staff were courteous and spoke respectfully to patients at all times. They listened to patients and responded appropriately. Of the patients who participated in the national GP Patient Survey in 2013, 86% said they found receptionists at the practice 'helpful'. A similar high level of satisfaction was found when respondents to the practice's own in-patient survey were asked about the reception team. Out of the respondents who participated, the majority said the reception team was 'good' or 'fair', and all of the respondents said they rated the respect they received as 'good' or 'fair'. However, one patient did tell us that it could sometimes be embarrassing when reception staff asked them why they needed an appointment, especially where other patients might be able to overhear. The majority of patients who responded to the in-practice patient survey said staff were either 'good' or 'fair' in relation to respecting their privacy.

Arrangements were in place to offer patients the option of having a chaperone present during their consultation. Of those patients who answered our question about the use of chaperones, all said a chaperone had been offered. Information about how to access a chaperone was available in the practice and on the practice web site. All staff, including GPs, had received chaperone training.

Patients were provided with the support they need to cope emotionally with their care and treatment. We were told the practice referred patients to CRUSE Bereavement Care which provides care and support to people who have been affected by a death. Clinicians also signposted patients, and those close to them, to a range of other types of support organisations. For example, we were shown a leaflet entitled 'First Step' which we were told GPs used to signpost patients with mental health needs to services that

Are services caring?

would offer them appropriate support. One of the GPs we spoke with said patients were also signposted to a range of other professionals who might be able to offer any additional support and treatment they needed, such as podiatry and smoking cessation clinics.

Involvement in decisions and consent

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the patients who participated in the national GP Patient Survey in 2013, 74% of respondents said the GP they visited had been 'good' at involving them in decisions about their care. We also saw that 85% of respondents said their GP had given them 'enough time' during their appointment. Of the 11 patients we spoke to during our visit, all said that they had been given enough time during their appointment. They also said their doctor or nurse had involved them in decision making and had explained treatment options in an understandable manner. We were told clinicians made referrals to a local advocacy service where this was thought to be appropriate. A GP we spoke with was able to describe the process they would go through when trying to support patients to make informed decisions and give informed consent.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The provider understood the different needs of the population it served and had made arrangements for these to be met. The practice had reviewed their access arrangements and introduced changes which had helped to improve patients' experience of using the service.

Our findings

Responding to and meeting people's needs

The provider understood the different needs of the population it served and took action to provide what patients needed.

The practice had recently been involved in the 'Diabetes Year of Care' programme. We were told that, following a review of 'lessons learnt' from their involvement in this programme, the practice made a decision to restructure the care and treatment provided to patients with, or who were at risk of developing, vascular related long-term conditions. Previously, patients with diabetes, heart disease, kidney disease, or those who had suffered a stroke, were seen at separate clinics. However, because patients with these conditions also often had other health related conditions, the practice made a decision to set up a vascular clinic which would enable patients with multiple conditions to have their needs reviewed all at the same time. We spoke to a nurse clinician who told us the vascular clinic had been set up to ensure all patients with long-term conditions were invited to attend for a 'comprehensive review of their conditions'. Nursing staff told us they felt they had the skills, competencies and knowledge needed to meet the needs of patients with long-term conditions and older people.

We were told the practice provided a range of services and clinics that were aimed at helping particular groups of patients to improve their health. For example, the practice provided patients with access to smoking cessation, weight management, dietetic advice, sexual health clinics and services aimed at promoting women's health and wellbeing. We found that the majority of patients on the practice heart disease register had been given lifestyle advice, including how they could increase physical activity, stop smoking, eat a healthy diet and consume alcohol safely. Patients with drugs and alcohol problems were able to access a weekly clinic provided by a GP at the practice. Patients with mental health needs would, where appropriate, be referred onto a local mental health organisation for extra support and help.

Reasonable adjustments had been made which helped patients with disabilities, or whose first language was not English, to access the service. For example, consultation rooms were available on the ground floor. Access to an

Are services responsive to people's needs?

(for example, to feedback?)

interpreter service was available. Patients with physical disabilities were able to access the front entrance of the building. The reception area and all consultations rooms were available on the ground floor.

Access to the service

The practice supported patients to receive a timely and accurate diagnosis, either directly from the practice or by referral to a specialist. Arrangements had been made which helped to ensure that test results were followed up in a timely manner.

The practice had recently taken steps to review the responsiveness of its appointment system. We were told significant changes had been made which the practice hoped would provide patients with more choice and improved access.

The practice offered patients different ways of accessing appointments. For example, patients were able to book appointments up to six weeks in advance as well as 'bookable on the day' appointments. The practice operated a duty doctor and a triage doctor system. This enabled the practice to respond more flexibly to patients with urgent same-day care needs requesting immediate appointments, including requests for home visits. Doctors carrying out home visits were allocated 'visiting zones' to help them use their time effectively and prioritise calls according to their urgency. An open access clinic was available each Monday afternoon for patients who needed to be seen 'on the day' for acute problems. This clinic provided patients with access to a GP and nurse practitioners. A short consultation surgery operated each afternoon from Tuesday through to Friday. This enabled the practice to offer appointments to patients needing to see a GP urgently.

Of the patients who participated in the national GP Patient Survey in 2013, the majority said the practice opened at times that were convenient to them. Again, a similar high level of satisfaction was found when the majority of respondents to the practice's own in-patient survey said opening hours were either 'good' or 'fair'. Of the patients who participated in the national patient survey, most said they found getting through to the practice was either 'good' or 'fair.' However, only 54% of the respondents who participated in the national GP Patient Survey said they found it 'easy' to get through to someone at the practice and 45% said they found getting through to the practice either 'not very easy' or 'not easy at all.'

Patients told us they were able to see a doctor of their choice, but that this sometimes meant they had to wait longer to do so. Some patients said they had experienced no problems accessing appointments. However, other patients said they sometimes had difficulties obtaining an appointment with a GP of their choice, or booking an appointment in advance. Two of the four patients who completed comment cards said they had experienced difficulties obtaining an appointment. One patient did tell us that they had waited at the surgery for an hour and 15 minutes for a pre-booked appointment. They said they had found this unacceptable as they had a small child with them. Of the respondents who completed the practice's own in-patient survey, the majority said they were satisfied with appointment waiting times. The practice manager told us they hoped that the improvements they had made to the appointments system would help address the concerns raised by patients.

The practice's brochure provided information about, for example, the range of services offered and how patients could obtain medical support outside of surgery hours. Health promotion literature, and information about services at the practice, was available in the reception area. The practice website provided patients with information about opening hours, how to obtain repeat prescriptions, and what to do in an emergency. This helped to ensure that patients were given appropriate information about what the practice provided and how they could promote their own health and wellbeing.

Concerns and complaints

The practice had a clear complaints policy which set out how complaints would be handled, and within what timescales. Although information about how to complain had been included in the practice leaflet and on its website, and was available in the practice, the majority of the 11 patients we spoke to said they would not know how to make a complaint.

Before we carried out our inspection, we asked the provider to send us a summary of the complaints they had received in the last 12 months. We were able to see from the information we were given that the practice had taken appropriate action to deal with the complaints they had received.

Are services well-led?

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

Summary of findings

There was a strong and visible leadership team with a clear vision and purpose. Governance structures were mostly robust and there were systems in place for managing risks.

Our findings

Leadership and culture

The service was well-managed and staff listened, learned and took action to make improvements. There was a clear focus on promoting and achieving clinical excellence in the quality of care they delivered to patients. Staff were committed to achieving the best possible outcomes for patients, whether this was in the way they delivered services to patients in hard to reach groups or those with complex long term conditions. The provider operated an open culture, actively sought feedback from staff and promoted their engagement in helping to improve the services provided to patients. Senior managers told us they valued their staff and created opportunities to promote good team work and a 'shared understanding of what the practice needed to do better to provide patients with good care and treatment'.

Governance arrangements

Governance arrangements were mostly effective and supported transparency and openness. We found care and treatment was provided by a multidisciplinary team in which full use was made of all the team members. Senior staff provided visible leadership and demonstrated they were familiar with the essential aspects of clinical governance. (Clinical governance is a framework through which GP practices hold themselves accountable for continually improving the quality of the services they offer.) Systems were in place to identify and manage risks. For example, the practice had a comprehensive business continuity plan to help ensure the service could be maintained in the event of foreseeable emergencies.

There was a well-established management structure and a clear allocation of responsibilities, such as clinical lead roles. We were able to talk with several GPs, nursing staff and the practice manager. All of them demonstrated a good understanding of their areas of responsibility and took an active role in trying to ensure patients received good care and treatment. There were systems and processes in place which facilitated the extraction of information to enable robust judgements to be made about performance and where improvements needed to be made.

Are services well-led?

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

Systems to monitor and improve quality and improvement

A range of systems were in place to monitor and improve quality and improvement. Staff had access to comprehensive guidance about how they should capture all patient contacts and other significant events such as referrals for further assessment and diagnosis and test results. Staff were aware of which staff had responsibility for ensuring that patient information, and outcomes of consultations, was correctly coded. The practice manager told us this helped ensure the practice was able to submit timely and accurate information to external bodies monitoring the performance of the service. We were shown evidence which confirmed regular audits were undertaken to ensure data quality was maintained to a good standard.

Patient experience and involvement

Arrangements were in place to encourage, hear and act on feedback from patients and staff. The practice had arranged for an external organisation to carry out its in-practice patient survey. The survey covered areas such as satisfaction with the performance of their doctor or nurse, and whether satisfactory systems were in place to ensure patient recall was effective. The practice manager told us the outcome of the patient survey was discussed at practice meetings to identify what improvements could be made to address the feedback received.

The practice did not have an active patient participation group (PPG). We were told there had been an active group but that this had not been the case for over two years. However, we were shown evidence which demonstrated that steps had recently been taken to promote the development of a PPG, including publicising information about the role of the PPG and asking for interested volunteers to contact the practice. The practice web site also included information about how to express an interest in joining the group.

Staff engagement and involvement

The practice promoted staff engagement and involvement. The staff we spoke to felt valued, and said they were an important part of the practice team. Staff said team work was really good. They said the whole team worked well together in a positive manner to deliver good patient care. Nurses said their opinions were sought and confirmed they felt involved in how the practice was managed and services were delivered. An established system of practice and clinical meetings was in place, and staff said this enabled them to hear about proposed changes and to provide feedback about 'what worked well and what was not working so well'. Minutes of meetings were kept so that all members of the team knew what issues had been discussed and what action points had been agreed.

Learning and improvement

Staff were provided with opportunities to continuously learn and improve. They told us they were provided with enough opportunities for continuous learning which enabled them to retain their professional registration or be successful in attaining revalidation with the General Medical Council. Staff told us their personal development was encouraged and supported. Nursing staff said as soon as any gaps in skills, knowledge or competencies were identified, arrangements would be made for them to complete the necessary training. Staff said in-house 'time out' sessions took place on a regular basis enabling staff to complete required training and obtain evidence for their continuing professional development. The practice demonstrated their strong commitment to learning by providing opportunities for GP registrars to complete their training at the practice. These systems enabled learning and promoted improvements.

Identification and management of risk

The team worked well together to address and resolve problems in the delivery of good patient care. Clinical staff participated in regular meetings where discussions took place about any concerns or significant events. The staff we spoke with told us the team worked well together to address and resolve the problems they encountered during their day-to-day work. Staff were able to tell us about improvements that had been made following the significant event reviews they had carried out. All patients told us they felt safe using the service. These arrangements supported practice staff to continuously learn and improve, and deliver safe patient care.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Patients were not protected against the risks associated with the unsafe use and management of medicines. This was because the arrangements for handling hospital discharge letters and other advisory letters, including the authorisation to supply prescribed medicines, were unsafe.