St Thomas Medical Group

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

St Thomas Health Centre was inspected on Wednesday 8 October 2014. This was a comprehensive inspection.

St Thomas Health Centre is one of four practices belonging to the partnership named St Thomas Medical Group, who provide a service to approximately 35,000 patients in the city of Exeter.

St Thomas Health Centre has a branch called Pathfinder Surgery. The Pathfinder branch, Exwick Health Centre and Exeter University Student Health Centre, were not inspected on this occasion.

St Thomas Health Centre provides primary medical services to approximately 15,500 patients living in the city of Exeter and the surrounding areas. The practice provides services to a diverse population age group and is situated in a city centre location.

There was a team of nine GP partners. GP partners hold managerial and financial responsibility for running the business. In addition there were four additional salaried GPs, ten registered nurses, four health care assistants, a practice manager, and additional administrative and reception staff.

Patients using the practice also had access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

We rated this practice as outstanding.

Our key findings were as follows:

The practice was well led and responded to patient need and feedback. Innovative and proactive methods were used to improve patient outcomes even where no financial incentives or contractual agreements were expected.

The practice was caring and had an active carer and patient support network which had identified lonely, isolated or vulnerable patients. The group had worked to provide voluntary services and support, which promoted well-being and reduce isolation.

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Patients reported having good access to appointments at the practice and liked having a named GP which, they told us improved their continuity of care. The practice was clean, well-organised, had good facilities and was well equipped to treat patients. There were effective infection control procedures in place.

Feedback from patients about their care and treatment was consistently positive. We observed a non-discriminatory, person-centred culture. Staff told us they felt motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Views of external stakeholders were very positive and aligned with our findings.

The practice was well-led and had a leadership structure in place with the practice manager playing a central role in the co-ordination of the running of the practice. Staff displayed a sense of mutual respect and team work. There were systems in place to monitor and improve quality and identify risk and systems to manage emergencies.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of mental capacity to make decisions about care and treatment, and the promotion of good health.

Suitable recruitment, pre-employment checks, induction and appraisal processes were in place and had been carried out thoroughly. There was a culture of further education to benefit patient care and increase the scope of practice for staff.

Documentation received about the practice prior to and during the inspection demonstrated the practice performed comparatively with all other practices within the clinical commissioning group (CCG) area.

Patients felt safe in the hands of the staff and felt confident in clinical decisions made. There were effective safeguarding procedures in place.

Significant events, complaints and incidents were investigated and discussed. Learning from these events was implemented and communicated to show what learning, actions and improvements had taken place.

We saw several areas of outstanding practice including:

The practice were responsive to the needs of patients and provided services even when the service provided was not included in the GP contract. For example:

- The practice nurses and health care assistants performed complex leg ulcer dressings in the practice following extended training at the local hospital with community nurses who had extended training in tissue viability. The practice nurses had also worked with the dermatology department at the local acute trust to obtain training and advice. St Thomas staff input meant patients were able to receive this complex treatment at the practice avoiding the need to attend the community leg ulcer clinic on the other side of the city. This service was over and above what was expected from the practice in the GP contract and had improved outcomes for patients.
- An additional service was provided by staff at the practice for patients with indwelling intravenous lines used for prolonged treatments. For example, chemotherapy, long term antibiotics and intravenous feeding. Patients were normally required to go to hospital for management of this intravenous line. However, staff at the practice had completed extended training to enable patients to receive care locally, at the practice.
- Staff at the practice and the Friends of St Thomas Health Centre had raised money to fund staff training to enable patients to receive a pain relieving gas for complex wound dressings. This service meant that patients could stay at home and be cared for in the community rather than remaining in hospital.

In addition, the practice had responded by making sure information was provided to help patients with learning disabilities understand the care available to them. For example, administration staff had recognised the literature given out regarding the practice and health checks was inadequate and had changed the documents to easy read versions for these patients.

The practice had a very active carers support and Friends of St Thomas Health Centre group. The group of volunteers was co-ordinated by a member of staff employed at the practice and offered services to all patients, but especially to isolated and lonely patients and carers. The group offered services such as lunch clubs for housebound patients, a telephone support

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service, sitting and befriending services, weekly social events and carers support groups. The aim of the service was to prevent isolation and loneliness of patients and carers.

The practice had recognised that some patients were not fit enough to join the city walking group or wanted to remain in a smaller group. The practice had worked with three other local practices to set up a 'strollers group' for patients, until they were fit enough or more confident to join the city walking group.

However, there were also areas of practice where the provider should make improvements.

The provider should ensure that:

- All clinical staff receive training in the Mental Capacity Act (2005).
- The GPs should offer each other the same level of support and risk assessments as they do for other staff at the practice, to proactively prevent, reduce and identify work related stress.

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 safe.

Patients we spoke with told us they felt safe, well cared for and confident in the care they received. .

Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment at all times.

Recruitment procedures and checks were completed as required to help ensure that staff were suitable and competent. Risk assessments were performed when a decision had been made not to perform a criminal records check on administration staff.

Significant events and incidents were investigated systematically and formally. Systems were in place to ensure that learning and actions had been taken and communicated following such investigations, and staff confirmed their awareness.

Staff were aware of their responsibilities in regard to safeguarding and the Mental Capacity Act 2005, although recent training had not been provided for all GPs and nursing staff. There were safeguarding policies and procedures in place that helped identify and protect children and adults who used the practice from the risk of abuse.

There were arrangements for the efficient management of medicines within the practice.

The practice was clean, tidy and hygienic. Arrangements were in place that ensured the cleanliness of the practice was consistently maintained. There were systems in place for the retention and disposal of clinical waste.

Are services effective?

Good

The practice is rated as outstanding for effective.

Systems were in place to help ensure that all GPs and nursing staff were up-to-date with both national institute for health and care excellence (NICE) guidelines and other locally agreed guidelines. Evidence confirmed that these guidelines were influencing and improving practice and outcomes for patients. The services provided and data showed that the practice was performing highly when compared to neighbouring practices in the CCG. The practice wasusing innovative and proactive methods to improve patient outcomes even where no financial incentives or contractual agreements were expected.

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Patients' needs were assessed and care iwas planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate and in addition to their roles. Effective multidisciplinary working was evidenced.

Regular completed audits were performed of patient outcomes which showed a consistent level of care and effective outcomes for patients. We saw evidence that audit and performance was driving improvement for patient outcomes.

There was a systematic induction and training programme in place with a culture of further education to benefit patient care and increase the scope of practice for staff.

The practice worked together efficiently with other services to deliver effective care and treatment and on occasions went above and beyond its contractual agreements to provide additional services for patients.

Are services caring?

Outstanding ☆

The practice is rated as outstanding for caring.

Data showed patients rated the practice higher than others for many aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a person-centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patients' choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Accessible information was provided to help patients understand the care available to them. For example, administration staff had attended training regarding learning disabilities and had recognised the literature given about the practice and health checks was inadequate. They changed the documents to easy read for these patients.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for responsive.

We found the practice had initiated many positive service improvements for their patient population that were over and above their contractual obligations, particularly for older patients, patients with long term conditions and carers. For example, the practice was commissioned to provide headache clinics. A GP at the practice had set up a headache clinic for patients who had problems with

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recurring headaches. Referrals were made from all over Devon. This service had reduced the need for all neurological referrals to be made to secondary care. The GP had undertaken extensive research and training.

The practice was supported by a very active patient participation group (PPG), carers support group and Friends of St Thomas Health Centre who helped with a number of the initiatives to benefit patients, including an improved appointment system, additional services and social interactions for isolated, lonely patients and carers. The practice had reviewed the needs of their local population and engaged with the NHS England local area team (LAT) and clinical commissioning group (CCG) to secure service improvements where these had been identified. It had also worked to provide additional services for patients.

Patients reported good access to the practice and a named GP providing continuity of care. Urgent appointments were available within the same day. The practice had the facilities and equipment to treat patients and meet their needs.

There was an accessible complaints system with evidence that the practice responded quickly to issues raised. There was evidence of shared learning, by staff and other stakeholders, from complaints.

Are services well-led?

Good

The practice is rated as good for well-led.

Staff were clear about the vision of the organisation and their responsibilities in relation to this. The strategy to deliver the vision was informal and not always regularly reviewed and discussed with staff. The practice carried out informal succession and business planning. There was a leadership structure in place. The practice manager played a central role in the coordination and running of the practice. Staff felt supported by management. There was a stable staff group and high level of job satisfaction and support for nursing and clerical staff. However, we did not see evidence that the same level of well-being for GPs was being monitored as effectively.

The practice had a number of systems, policies and procedures to monitor risk, clinical effectiveness and governance and to share learning from any events.

The practice valued and proactively sought feedback from patients and staff and this had been acted upon. The practice had an active patient participation group (PPG), carer support group and Friends

Summary of findings

of St Thomas Health Centre group. These groups improved services for patients and influenced changes at the practice. Staff had received inductions, regular performance reviews and had attended staff meetings and events.

Summary of findings

What people who use the service say

We spoke with nine patients during our inspection and a representative of the patient participation group (PPG).

The practice had provided patients with information about the Care Quality Commission prior to the

inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected 43 comment cards, 35 of which contained detailed positive comments. The remaining eight cards also contained positive comments but also suggestions and observations which were given to the practice manager.

Comment cards stated that patients appreciated the caring attitude of the staff and for the staff who took time to listen effectively. There were many comments praising individually named GPs and nurses. Comments also highlighted a confidence in the advice and medical knowledge and praise for the continuity of care and not being rushed. There were 21 comments about a recent improvement to the appointment system and praise for the same day illness appointments.

These findings were reflected during our conversations with patients and discussion with the PPG member. The feedback from patients was overwhelmingly positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients quoted they were happy, very satisfied and said they had no complaints and got good treatment. Patients told us that the GPs and nursing staff were excellent.

Patients were happy with the appointment system and said it was easy to make an appointment.

Patients appreciated the service provided and told us they had no concerns or complaints and could not imagine needing to complain.

Patients were satisfied with the facilities at the practice and commented on the building being clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients found it easy to get repeat prescriptions and said they thought the information provided and the practice website was good.

Areas for improvement

Action the service SHOULD take to improve

- All clinical staff should receive training in the Mental Capacity Act 2005.
- The GPs should offer each other the same level of support and risk assessments as they do for other staff at the practice, to proactively prevent, reduce and identify work related stress.

Outstanding practice

The practice were responsive to the needs of patients and provided services even when the service provided is not included in the GP contract. For example

- The practice nurses and health care assistants performed complex leg ulcer dressings in the practice following extended training at the local hospital with community nurses who had extended training in tissue viability. The practice nurses had also worked with the dermatology department at the local acute trust to obtain training and advice. St Thomas staff input meant patients were able to receive this complex treatment at the practice avoiding the need to attend the community leg ulcer clinic on the other side of the city. This service was over and above what was expected from the practice in the GP contract and had improved outcomes for patients.

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- An additional service was provided by staff at the practice for patients with indwelling intravenous lines used for prolonged treatments. For example, chemotherapy, long term antibiotics and intravenous feeding. Patients were normally required to go to hospital for management of this intravenous line. However, staff at the practice had completed extended training to enable patients to receive care locally, at the practice.
- Staff at the practice and the Friends of St Thomas Health Centre had raised money to fund staff training to enable patients to receive a pain relieving gas for complex wound dressings. This service meant that patients could stay at home and be cared for in the community rather than remaining in hospital.
- The practice had responded by making sure information was provided to help patients with learning disabilities understand the care available to them. For example, administration staff had recognised the literature given out regarding the practice and health checks was inadequate and had changed the documents to easy read versions for these patients.
- The practice has a very active carers support and Friends of St Thomas Health Centre group. The group of volunteers was co-ordinated by a member of staff employed at the practice and offered services to all patients, but especially to isolated and lonely patients and carers. The group offered services such as lunch clubs for housebound patients, a telephone support service, sitting and befriending services, weekly social events and carers support groups. The aim of the service was to prevent isolation and loneliness of patients and carers.
- The practice had recognised that some patients were not fit enough to join the city walking group or wanted to remain in a smaller group. The practice had worked with three other local practices to set up a 'strollers group' for patients, until they were fit enough or more confident to join the city walking group.

St Thomas Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included two additional CQC inspectors, a GP specialist advisor, a practice manager specialist advisor and a CQC pharmacist.

Background to St Thomas Medical Group

St Thomas Health Centre is one of four practices managed under the partnership named St Thomas Medical Group. The Pathfinder Surgery, Exwick Health Centre and Exeter University Student Health Centre were not inspected on this occasion. For purposes of this inspection we visited St Thomas Health Centre. Overall St Thomas Medical Group care for approximately 35,000 patients with St Thomas Health Centre and the Pathfinder Surgery jointly looking after approximately 15,500 patients.

St Thomas Health Centre provides primary medical services to people living in the city of Exeter and the surrounding areas. The practice provides services to a diverse population age group and is situated in a city centre location.

The St Thomas Health Centre and Pathfinder Surgery share a team of nine GP partners. GP partners hold managerial and financial responsibility for running the business. In addition there were four additional salaried GP, ten registered nurses, four health care assistants, a practice manager, and additional administrative and reception staff.

Patients using the practice also have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

St Thomas Health Centre is open between Monday and Friday 8.30am – 6pm with additional 7am appointments on Thursdays and late night appointments on Tuesdays and Wednesdays until 8pm. These appointments are designed for patients who are unable to access appointments during normal office hours. Outside of these hours a service is provided by another health care provider.

There is a same day illness clinic for patients and telephone request service for patients who just want to speak with a GP. Routine appointments are bookable up to three weeks in advance.

Why we carried out this inspection

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

How we carried out this inspection

Before conducting our announced inspection of St Thomas Health Centre, we reviewed a range of information we held

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about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, the local clinical commissioning group and local voluntary organisations.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

We carried out our announced visit on Wednesday 8 October 2014. We spoke with nine patients and 26 staff at the practice during our inspection and collected 43 patient responses from our comments box which had been displayed in the waiting room. We obtained information from and spoke with the practice manager, ten GPs, nine receptionists/clerical staff, seven nursing staff and the practice pharmacist. We observed how the practice was run and looked at the facilities and the information available to patients. We also spoke with a representative from the patient participation group (PPG).

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

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?

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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Are services safe?

Our findings

Safe Track Record

The practice had a systematic, clear process in place for reporting, recording, monitoring and communicating findings from significant events. The practice kept records of significant events that had occurred and used these as part of a quality assurance process to monitor any trends. There was evidence that appropriate learning had taken place where necessary and that the findings were communicated to relevant staff. Staff were aware of the significant event reporting process and how they would verbally escalate concerns within the practice. All staff we spoke with felt very able to raise any concern however small. Staff knew that following a significant event, the GPs undertook an analysis to establish the details of the incident and the full circumstances surrounding it. Staff explained that the regular three monthly significant event meetings were well structured and well attended by all representatives from each team.

Learning and improvement from safety incidents

At St Thomas Health Centre the process following a significant event or complaint was formalised and followed a set procedure. GPs discussed the incidents as they occurred but more formally at three monthly clinical meetings where actions and learning outcomes were shared with all staff. We were given four clear examples of where practice and staff action had been prompted to change as a result of incidents. These included changes in protocols, additional training for staff and further communication for all staff.

There were systems in place to make sure any medicines alerts or recalls were actioned by staff. There were systems to record any incidents occurring (or 'near misses') so that lessons could be learnt and procedures changed if necessary to reduce the risks in future.

There were systems in place to make sure any medicines alerts or recalls were actioned by staff.

Reliable safety systems and processes including safeguarding

Patients told us they felt safe at the practice and staff knew how to raise any concerns. A named GP had a lead role for safeguarding. They had been trained to the appropriate advanced level. There were policies in place to direct staff on when and how to make a safeguarding referral. This included flow charts displayed for staff reference. The policies and flow charts included information on external agency contacts, for example the local authority safeguarding team.

There was an annual meeting schedule to show that staff could raise safeguarding concerns about vulnerable adults at these meetings. Vulnerable patients were also discussed at monthly palliative care meetings and other relevant health professionals were involved.

We spoke with two external health care professionals who said communication with the practice staff was excellent and collaborative working was effective.

Practice staff said communication between health visitors and the practice was good and any concerns were followed up. For example, if a child failed to attend routine appointments, looked unkempt or was losing weight the GP could raise a concern for the health visitor to follow up.

The computer based patient record system allowed safeguarding information to be alerted to staff but relied on staff looking for this information. This had been identified and was due to be improved with the introduction of a new computer system so that when a vulnerable adult or 'at risk' child had been seen by different GP or nurse , staff would be alerted. Staff had received safeguarding training and were aware of who the safeguarding leads were. Staff also demonstrated knowledge of how to make a patient referral or escalate a safeguarding concern internally using the whistleblowing policy or safeguarding policy.

Medicines Management

The GPs were responsible for prescribing medicines at the practice and there were several dispensing pharmacies nearby.

The practice employed a pharmacist prescriber for six hours each week. This pharmacist was also involved with helping with clinical audits involving medicines, and implementing good practice guidance around prescribing and medicines management.

The control of repeat prescriptions was managed well. Patients were satisfied with the repeat prescription processes. They were notified of health checks needed before medicines were issued. Patients explained they could use the box in the surgery, send an e-mail, or use the on-line request facility for repeat prescriptions.

Are services safe?

There were systems in place to ensure that all prescriptions were authorised by the prescriber, and that patients' medicines were reviewed regularly. The computer system allowed for highlighting high risk medicines, for checking for allergies and interactions and processes for more detailed monitoring.

Patients were informed of the reason for any medication prescribed and the dosage. Where appropriate patients were warned of any side effects, for example, the likelihood of drowsiness.

All of the medicines we saw were in date. All storage areas were appropriate, clean and well ordered. There were appropriate arrangements and records for the disposal of these medicines. Vaccines were stored appropriately and there were auditing systems in place to ensure that the cold chain was maintained, so these products would be safe and effective to use. Other medicines kept at the practice for use by GPs and practice nurses were stored safely and systems were in place to monitor expiry dates.

We found that medicines kept in GP bags were the responsibility of each GP to maintain supplies and ensure expiry dates were checked. There were policies explaining the practice nurses would monitor this.

We saw that there were detailed policies and standard operating procedures in place to guide staff on the safe management and handling of medicines, and that these were regularly updated.

Cleanliness & Infection Control

We left comment cards at the practice for patients to tell us about the care and treatment they receive. We received 43 completed cards. Of these, 10 specifically commented on the building being clean, tidy and hygienic. Patients told us staff used gloves and aprons and washed their hands.

The practice had 26 policies and procedures on infection control which included managing spillages, needle stick injury, waste, cleaning and control of substances hazardous to health. There were a number of policies giving staff guidance on how to manage outbreaks of diseases including Ebola. We spoke with the infection control lead nurse and lead GP who explained that the practice had a regular process of infection control audit and re audit. The most recent audits had identified and prompted the introduction of wall mounted couch roll, gloves, hand soap and towels. Staff had access to supplies of protective equipment such as gloves and aprons, disposable couch roll and surface wipes. The nursing team were aware of the steps they needed to take to reduce risks of cross infection and had received updated training in infection control.

Treatment rooms, public waiting areas, toilets and treatment rooms were visibly clean. There was a cleaning schedule carried out and monitored. There were hand washing posters on display to show effective hand washing.

Clinical waste and sharps were being disposed of in safe manner. There were sharps bins and clinical waste bins in the treatment rooms. The practice had a contract with an approved contractor for disposal of waste. Clinical waste was stored securely in a dedicated secure area whilst awaiting its collection from a registered waste disposal company.

Equipment

Emergency equipment available to the practice was within the expiry dates. The practice had an effective system using checklists to monitor the dates of emergency medicines and equipment which ensured they were discarded and replaced as required.

Equipment such as the weighing scales, blood pressure monitors and other medical equipment were serviced and calibrated where required.

Portable appliance testing (PAT), where electrical appliances were routinely checked for safety by an external contractor, was last tested in September 2012. The next test was due later this year.

Staff told us they had sufficient equipment at the practice.

Staffing & Recruitment

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well. The practice had a low turnover of staff and many staff at the practice had been there for a number of years. The practice said they used locums as staff cover but tried to use the same one for continuity. GPs told us they also covered for each other during shorter staff absences.

The practice used a clear system to ensure the workload for staff was shared equally and cover was available when GPs were on leave or absent.

Recruitment procedures were in place and staff employed at the practice had undergone the appropriate checks prior

Are services safe?

to commencing employment. Clinical competence was assessed at interview and interview notes kept to show the process was fair and consistent. Once in post staff completed a job specific induction which consisted of ensuring staff met competencies and were aware of emergency procedures.

Criminal records checks were only performed for GPs, nursing staff and administrative staff who had direct access with patients. Recorded risk assessments had been performed explaining why some clerical and administrative staff had not had a criminal records check. The practice manager was in the process of considering performing criminal record checks on administrative staff who were named as chaperones.

The practice had disciplinary procedures to follow should the need arise.

The registered nurses' Nursing and Midwifery Council (NMC) status was completed and checked annually to ensure they were on the professional register to enable them to practice as a registered nurse.

Monitoring Safety & Responding to Risk

The practice had a suitable business continuity plan that documented their response to any prolonged period of events that may compromise patient safety. For example, this included computer loss and lists of essential equipment. This had recently been tested when the computer system failed. Staff had reviewed this following the event to make sure staff were aware of how to get the necessary information from alternative sources.

Nursing staff received any medical alert warnings or notifications about safety by email or verbally from the GPs or practice manager.

There was a system in operation to ensure one of the nominated GPs covered for their colleagues, for example home visits, telephone consultations and checking blood test results.

Regular completed audits were performed of patient outcomes which showed a consistent level of care and effective outcomes for patients. We saw evidence that audit and performance was driving improvement for patient outcomes.

Arrangements to deal with emergencies and major incidents

Appropriate equipment was available and maintained to deal with emergencies, including if a patient collapsed. Administration staff appreciated that they had been included on the basic life support training sessions.

Suitable emergency medicines and equipment was available at the practice, and systems were in place to make sure these were checked and maintained regularly.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

There were examples where care and treatment followed national best practice and guidelines. For example, the practice had an on line formulary to access guidance. Emergency medicines and equipment held within the practice followed the guidance produced by the Resuscitation Council (UK). The practice followed the National Institute for Health and Care Excellence (NICE) guidelines and had formal clinical meetings where latest guidance would be discussed. We saw that where required, guidance from the Mental Capacity Act 2005 had been followed. Guidance from national travel vaccine websites had been followed by practice nurses. The practice had also provided patient information on advanced decisions.

The practice used the quality and outcome framework (QOF) to measure their performance. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice showed they generally achieved higher than national average scores in areas that reflected the effectiveness of care provided. The local clinical commissioning group (CCG) data demonstrated that the practice performed well in comparison to other practices within the CCG area.

Management, monitoring and improving outcomes for people

The practice was using innovative and proactive methods to improve patient outcomes including where no financial incentives or contractual agreements were expected. For example providing additional training for staff and additional services for patient benefit. The carers support group and Friends of St Thomas Health Centre were also instrumental in providing additional services for lonely and isolated patients and for carers.

The GPs used the QOF data to monitor the service they provided but also to improve and identify where additional services may be necessary. For example, providing additional clinics for patients.

The practice had a system to identify more vulnerable patients. The GPs were included in a local complex care team (CCT) which met to discuss vulnerable patients, as well as those at risk, every two weeks. The team also included community nurses, a community matron, a domiciliary pharmacist, social workers, occupational therapists and representatives from the voluntary sector. The work undertaken by the GPs and team contributed to the practice's participation in the national initiative to avoid the need to admit patients to hospital.

GPs in the practice undertook minor surgical procedures, such as vasectomies, in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. There was evidence of regular clinical audit in this area, which was used by GPs for revalidation and personal learning purposes. For example one GP had performed an infection rate audit to ensure best practice was being followed.

Effective Staffing, equipment and facilities

All of the GPs in the practice participated in the appraisal system leading to revalidation of their practice over a five-year cycle. The GPs we spoke with told us and demonstrated that these appraisals had been appropriately completed. One of the GPs was a nominated GP for appraising other GPs in the county.

The practice was a teaching practice for new GPs. The GP locum had been a trainee at the practice and said the support received had been very good.

Nursing and administration staff had received an annual formal appraisal and kept up to date with their continuous professional development programme. We saw documented evidence to confirm that this process was used.

A process was in place to ensure clerical and administration staff received regular formal appraisal.

There was a comprehensive induction process for new staff which was adapted for the role of each person.

The staff training programme was monitored to make sure staff were up to date with training the practice had listed as mandatory. This included basic life support, safeguarding, fire safety and infection control. Staff training was discussed at appraisal and staff could attend any relevant external training to further their development and benefit patient care. Examples of this included complex wound dressings (usually the role of district nurses) and care of intravenous catheters.

Are services effective?

(for example, treatment is effective)

There was a set of policies and procedures for staff to use and additional guidance or policies located on the computer system.

Working with other services

There was evidence of working with other services. This included working with the multidisciplinary team at the CCT meeting to discuss vulnerable patients, meetings with palliative care and hospice care staff and individual communication with other health care professionals. This included physiotherapists, occupational therapists, health visitors, district nurses, community matrons and the mental health team.

Communication systems had been set up to allow the Out of Hours service GPs to access patient records, with their consent, using a local computer system. GPs were informed when patients were discharged from hospital. This prompted any medicine reviews that were needed.

Other examples of working with others included working with counsellors from the depression and anxiety service (DAS) and with mental health charity representatives.

Staff volunteers had also worked with community groups as part of an anti-graffiti team in the local area. Staff had volunteered to clean graffiti from local buildings to make visiting the practice more pleasant for patients.

Involvement in decisions and consent

Patients we spoke with told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they had sufficient time to discuss their concerns with their GP and said they never felt rushed. Feedback from the comment cards showed that patients had different treatment options discussed with them.

The practice used a variety of ways of recording patients had given consent depending on the procedure. We saw evidence of patient consent for procedures including immunisations, injections, and minor surgery.

Patients told us that nothing was undertaken without their agreement or consent at the practice.

Where patients did not have the mental capacity to consent to a specific course of care or treatment, the practice had acted in accordance with the Mental Capacity Act 2005 to make decisions in the patient's best interest. Staff were knowledgeable and sensitive to this subject, although not all clinical staff had received the training. We were given specific examples by the GPs where they had been involved in best interest decisions.

Health Promotion & Prevention

There were specific clinics held for patients with complex illnesses and diseases. This was used as an opportunity to discuss lifestyle, diet and weight management. A full range of screening tests were offered for diseases such as prostate cancer, cervical cancer and ovarian cancer. Vaccination clinics were organised on a regular basis which were monitored to ensure those that needed vaccinations were offered. At the time of the inspection the flu clinics were being promoted in the waiting areas.

All patients with learning disability were offered a physical health check each year.

Staff explained that when patients were seen for routine appointments, prompts appeared on the computer system to remind staff to carry out regular screening, recommend lifestyle changes, and promote health improvements which might reduce dependency on healthcare services. These prompts were also communicated at the QOF monitoring meetings.

Patients were encouraged and supported to adopt healthy lifestyles and the practice recognised the need to maintain fitness and healthy weight management. The practice worked with a small number of other practices to provide a walking group for patients who did not feel confident to join the city walking group. The carers support group also hosted a weight monitoring service and a monthly lifestyle session at the social events.

There was a range of leaflets and information documents available for patients within the practice and on the website. These included information on family health, travel advice, long term conditions and minor illnesses. These links were simple to locate.

Family planning, contraception and sexual health screening was provided at the practice.

The practice offered a full travel vaccination service and was a nominated yellow fever centre.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with told us they felt well cared for at the practice. They told us they felt they were communicated with in a caring and respectful manner by all staff. Patients spoke highly of the staff and GPs. We did not receive any negative comments about the care patients received.

We left comment cards at the practice for patients to tell us about the care and treatment they received. We collected 43 completed cards which contained very detailed positive comments. All comment cards stated that patients were grateful for the caring attitude of the staff who took time to listen effectively.

Patients were not discriminated against and told us staff had been sensitive when discussing personal issues.

We saw that patient confidentiality was respected within the practice. The waiting areas had sufficient seating and were located away from the main reception desk which reduced the opportunity for conversations between reception staff and patients to be overheard. There were additional areas available should patients want to speak confidentially away from the reception area. We heard, throughout the day, the reception staff communicating pleasantly and respectfully with patients.

Conversations between patients and clinical staff were confidential and always conducted behind a closed door. Window blinds, sheets and curtains were used to ensure patient's privacy. The GP partners' consultation rooms were also fitted with curtains to maintain privacy and dignity.

We discussed the use of chaperones to accompany patients when consultation, examination or treatment was carried out. A chaperone is a member of staff or person who is present with a patient and a medical practitioner during a medical examination or treatment. Posters displayed informed patients they were able to have a chaperone should they wish. Administration staff at the practice had received training and had acted as chaperones as required. They understood their role was to reassure and observe that interactions between patients and doctors were appropriate.

Care planning and involvement in decisions about care and treatment

Patients told us that they were involved in their care and treatment and referred, in their comments, to an ongoing dialogue of choices and options. Comment cards related patients' confidence in the involvement, advice and care from staff and their medical knowledge, the continuity of care, not being rushed at appointments and being pleased with the referrals and ongoing care arranged by practice staff. We were given specific examples where the GPs and nurses had taken extra time and care to diagnose complex conditions.

There were 21 patient comment cards which made reference to an improved appointment system now being used at the practice. Patients and the patient reference group representative said this change had occurred after feedback from patients. Patients said they had been involved in this decision and found it of benefit.

Patient/carer support to cope emotionally with care and treatment

The practice survey information showed patients were positive about the emotional support provided and rated it well. For example, 91% of the 146 respondents in the March 2014 survey stated that they were treated with kindness and care. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this information. For example, these highlighted staff responded compassionately when patients needed help and provided support when required.

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

The practice had a very active carers support and Friends of St Thomas Health Centre group. The group of volunteers was co-ordinated by a member of staff employed at the practice and offered services to all patients but especially to isolated and lonely patients and carers. The group offered services such as lunch clubs for housebound patients, a telephone support service, sitting and befriending services, weekly social events and carers support groups. The service prevented isolation and loneliness of patients and carers.

Are services caring?

Staff told us families who had suffered bereavement were contacted by their usual GP or if appropriate a volunteer from the carers support group and Friends of St Thomas Health Centre group. GPs said the personal list they held helped with this communication. There was a counselling service available for patients to access.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients we spoke with told us they felt the staff at the practice were responsive to their individual needs. They told us that they felt confident the practice would meet their needs. GPs told us that when home visits were needed, they were normally made by the GP who was most familiar with the patient.

Systems were in place to ensure any patient who needed referral, including urgent referrals, for secondary care and routine health screening including cervical screening, were made in a timely way. Patients told us that their referral to secondary care had always been discussed with them and arranged in a timely way.

An effective process was in place for managing blood and test results from investigations. When GPs were on holiday the other GPs covered for each other. Results were reviewed within 24 hours, or 48 hours if test results were routine. Patients said they had not experienced delays receiving test results.

The practice was responsive to the needs of patients and provided services including when the service provided was not included in the GP contract. For example, to improve local access for patients, the practice nurses and health care assistants had attended the leg ulcer clinic held by community tissue viability nurses in the local hospital and visited the dermatology ward at the local hospital. This provided education which enabled them to treat several patients each week in the practice, which in turn reduced the need for patients to travel to the local acute hospital. This service is over and above what is expected from the practice in the contract.

An additional service provided by staff at the practice was a service for patients with specialist intravenous catheters used for prolonged treatments. For example, chemotherapy, long term antibiotics and intravenous feeding, for which patients are usually required to go to hospital for management. However, staff at the practice had completed extended training to enable patients to receive care at the practice.

Staff at the practice and the Friends of St Thomas Health Centre had also raised funds and received training to enable patients to receive a pain relieving gas for complex wound dressings. This service meant that patients could be cared for in the community rather than remaining in hospital.

The practice was commissioned by the local clinical commissioning group (CCG) to provide regular headache clinics. A GP at the practice had initially set up a headache clinic for St Thomas patients who had problems with recurring headaches. This service was then extended with patients now being referred from all over Devon, thus preventing the need for all patients to be referred to the acute hospital. The GP had undertaken extensive research and training.

The practice had a patient participation group (PPG) in place. Members of this group were active in providing feedback about the services. For example, following a patient participation survey it was identified that patients had not been happy with the appointment system. As a result the practice had introduced a same day illness clinic which was proving popular with patients. The PPG members said they were encouraged to contribute suggestions.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. Staff said no patient would be turned away, but there were no homeless patients registered at the practice because there was a specific GP service for homeless people in the city.

The number of patients with a first language other than English was low and staff said they knew these patients well and were able to communicate well with them. The practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

There was level access to the entrance of the practice and the majority of consulting rooms were also on level access. There was a lift in the building but alternative treatment rooms and office space was also available for patients and staff who did not want to use the lift. The practice had an open waiting area and sufficient seating. The reception and waiting area had sufficient space for wheelchair users.

We saw no evidence of discrimination when making care and treatment decisions.

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Patients were able to access the service in a way that was convenient for them and said they were happy with the system. This view was reflected in 42 of the 43 comment cards we received. Discussions and comment card feedback showed that patients were happy with the arrangements in place and were pleased with the recent changes to the appointment system.

The GPs provided a personal patient list system. These lists were covered by colleagues when GPs were absent. Patients appreciated this continuity and GPs stated it helped with communication.

Information about the appointment times were found on the practice website and within the practice. Patients were informed of the out of hours arrangements when the practice was closed by a poster displayed in the practice, on the website and on the telephone answering message.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Patients told us they had no complaints and could not imagine needing to complain. Patients were aware of how to make a complaint and one comment card said previous concerns had been acted upon and managed well.

The posters displayed in the waiting room and patient information leaflet explained how patients could make a complaint. The practice website also contained clear information on how patients could make a complaint.

Records were kept of complaints which showed that responses and investigations were timely and completed to the satisfaction of the patient. Records also included evidence of any learning or actions taken following complaints. We saw action taken included letters of apology, offers of further communication and changes in procedures at the practice.

Staff were able to describe what learning had taken place following any complaint. Complaints were discussed as a standing agenda item at the significant event meetings held every three months.

Are services well-led?

(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 and a formal mission statement which stated the practice aimed to provide the community with high quality care whilst working with a team of health care professionals. Staff knew about the mission statement and of the practice vision and values and knew what their responsibilities were in relation to these.

GPs and other members of staff talked of future plans, succession planning and changes in the business. However, this information had not been collated in a formal business plan, so could not be kept under review in a structured way during the monthly management meetings or three monthly partner meetings.

Governance Arrangements

Staff were familiar with the governance arrangements in place at the practice and said that systems used were both informal and formal. Any clinical or non clinical issues were discussed amongst staff as they arose. For example, incidents were often addressed immediately and communicated through a process of face to face discussions and email. These issues were then followed up more formally at the three monthly significant event meetings or at clinical meetings. Staff explained these meetings were well structured, well attended and a safe place to share what had gone wrong.

The practice used the quality and outcomes framework (QOF) to assess quality of care as part of the clinical governance programme. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF scores for St Thomas health centre were consistently above the national average.

The clinical auditing system used by the GPs assisted in driving improvement. All GPs were able to share examples of audits they had performed. In addition to the incentive led audits there was a real sense that GPs wanted to perform audits to improve the service for patients and not just for their revalidation or QOF scores. These examples included medication audits, audits on complications following minor surgery. Audits were thorough and followed a complete audit cycle, but were not always readily available as a resource for trainees and staff to refer to.

Leadership, openness and transparency

There was a stable staff group. Many staff had worked at the practice for many years and were positive about the open culture within the practice. Nursing and administration staff spoke positively about the communication, team work and their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work.

GPs said there was support for each other when it was identified as being needed. However, we did not see the same level of proactive support or risk assessment given by the GPs to themselves as a staff group. For example, risk assessments were in place to identify stress in the nursing team and administration team, but this assessment had not been performed for the GPs. We noted that the GPs did not routinely meet on a daily or weekly basis to support one another, leading to some GPs working in isolation and not receiving the social and informal support from one another.

Staff said that even though the practice was large, communication was still effective through day to day events, email and more formally though meetings and formal staff appraisal.

Staff talked of a clear leadership structure in place and we noted that the practice manager played a central role in the leadership and running of the practice. There were named members of staff in lead roles. For example there was a clinical governance lead, lead nurse and GP for infection control, a lead GP for safeguarding and identified partners for commissioning, prescribing, complaints and research. Staff spoke about effective team working, clear roles and responsibilities but within a supportive non-hierarchical organisation. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns. Staff described an open culture within the practice and opportunities to raise issues at team meetings.

Are services well-led?

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

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

Patient feedback was valued by the practice. This was demonstrated by the recent change in appointment system following a patient survey.

The practice had a patient participation group (PPG). The PPG representative who came to the inspection said the practice manager and GP representative were keen to encourage patient feedback and involvement. The PPG said they were regularly consulted about various issues and had been able to influence this decision and suggest additional ideas.

The PPG was advertised on the practice website along with information on how patients could offer feedback.

Management lead through learning & improvement

A standardised, formal, systematic process was followed to ensure that learning and improvement took place when events occurred or new information was provided. For example, the practice had a calendar of meeting dates to discuss current issues. There was formal protected time set aside for continuous professional development for staff and access to further education and training as needed.

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. The practice had a suitable business continuity plan to manage the risks associated with a significant disruption to the service. This included, for example, if the electricity supply failed, IT was lost or if the telephone lines at the practice failed to work.

There were environmental assessments for the building. For example, annual fire assessments, electrical equipment checks, control of substances hazardous to health (COSHH) assessments and visual checks of the building had been maintained.