

Farnham Medical Centre

Quality Report

The Farnham Medical Centre, 435 Stanhope Road,
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Farnham Medical Centre on 22 September 2016. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses.
- Risks to patients were assessed and well managed.
- Outcomes for patients who use services were good.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff were consistent and proactive in supporting patients to live healthier lives through a targeted approach to health promotion. Information was provided to patients to help them understand the care and treatment available
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

- The practice had a system in place for handling complaints and concerns and responded quickly to any complaints.
- The practice had reviewed their telephone and appointment system, following feedback from patients. This had improved and they were due to carry out a review of the changes implemented.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure in place and staff felt supported by management. The practice sought feedback from staff and patients, which they acted on.
- Staff throughout the practice worked well together as a team.
- The practice was aware of and complied with the requirements of the duty of candour.

We saw an area of outstanding practice which was:

- The practice was part of a frailty/multi-morbidity project. This involved identifying patients who were either palliative or housebound who had polypharmacy and three or more long term conditions. Polypharmacy is the use of four or more

Summary of findings

medications by a patient. A visit was arranged to see the patient and an advanced care plan was compiled. Patients who had been seen so far in the project included 20 in nursing homes and 35 in their own

home. This had resulted in medication reviews and as a result of this there were further investigations with referrals to the memory clinic, continence clinic and geriatric assessments.

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?

The practice is rated as good for providing safe services.

Nationally reported data did not identify any risks relating to safety. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. Risks to patients were assessed and well managed.

Lessons were shared to make sure action was taken to improve safety in the practice. When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, and verbal or written apologies.

The practice was clean and hygienic and good infection control arrangements were in place.

The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe.

Staff recruitment and induction policies were in operation and staff had received Disclosure and Barring Service (DBS) checks where appropriate. Chaperones were available if required and staff who acted as chaperones had undertaken appropriate training.

Good



Are services effective?

The practice is rated as good for providing effective services.

Patients' needs were assessed and care was planned and delivered in line with current legislation. Arrangements had been made to support clinicians with their continuing professional development. There were systems in place to support multi-disciplinary working with other health and social care professionals in the local area. Staff had access to the information and equipment they needed to deliver effective care and treatment and had received training appropriate to their roles.

Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were comparable with local clinical commissioning group (CCG) and national averages. The practice used the QOF as one method of monitoring effectiveness and were able to demonstrate that they had achieved 98.5% of the points available to them for 2014/15.

There was evidence of clinical audit activity and improvements made to patient care and patient outcomes as a result of this.

Staff received annual appraisals and were given the opportunity to undertake both mandatory and non-mandatory training.

Good



Summary of findings

Are services caring?

The practice is rated as good for providing caring services.

Most patients we spoke with during the inspection and those that completed Care Quality Commission comments cards said they were treated with compassion, dignity and respect and they felt involved in decisions about their care and treatment. Information for patients about the service was available. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Results from the National GP Patient Survey published in July 2016 were comparable with local CCG and national averages in respect of providing caring services. For example, 90% of patients who responded to the survey said the last GP they saw or spoke to was good at listening to them (CCG average 91% and national average 89%).

The practice identified carers and ensured they were signposted to appropriate advice and support services. At the time of our inspection they had identified 329 of their patients as being a carer (approximately 2.65% of the practice patient population).

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

The practice was able to demonstrate that they continually monitored the needs of their patients and responded appropriately. The practice had become involved in a number of initiatives to improve services. This included being part of a frailty/ multi-morbidity project, with the aim of providing better care to the elderly.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and evidence showed that the practice responded quickly to issues raised and identified themes arising from them. However, there was no information for patients in response to complaint letters regarding taking the complaint further such as to NHS England or The Parliamentary and Health Service Ombudsman.

The practice was concerned with the satisfaction rates for patients experience of getting through to the surgery by phone, making an appointment and the waiting time for their consultation. They were also aware that there were several complaints regarding this. A new telephone system with more phone lines to the practice had been put in place from April 2016. The appointment system was reviewed

Good



Summary of findings

and more appointments were made available. The practice had planned to carry out a review of the changes in October 2016 to test their effectiveness. They had already noticed that complaints had reduced as a result of the changes.

Are services well-led?

The practice is rated as good for being well-led.

The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this.

There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity.

There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. The practice had a comprehensive five year business plan which documented priorities such as increasing the patient list size and improving the appointment system.

The provider was aware of and complied with the requirements of the Duty of Candour regulation. The practice had systems in place for knowing about notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.

The practice sought feedback from staff and patients, which it acted on. There was a strong focus on continuous learning and improvement at all levels.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population.

The practice was part of a frailty/multi-morbidity project. This involved identifying patients who were either palliative or housebound who had polypharmacy and three or more long term conditions. Polypharmacy is the use of four or more medications by a patient. A visit was arranged to see the patient and an advanced care plan was compiled. Patients who had been seen so far in the project included 20 in nursing homes and 35 in their own home. This had resulted in medication reviews and further investigations with referrals to the memory clinic, continence clinic and geriatric assessments.

The practice provided a dedicated GP to the three care homes which they provided services to. There were fortnightly 'ward rounds' at the care homes. There were reviews of all of these patients who had been discharged from hospital. The practice had also recently been awarded the contract to provide services to a newly opened re-enablement service.

The practice had a palliative care lead in the practice and a palliative register which was discussed at the weekly clinical meeting. There was a named and second GP for each patient on the register.

All patients over the age of 75 had a named GP. The practice offered home visits usually by the same GP. Prescriptions could be sent to any local pharmacy electronically.

Good



People with long term conditions

The practice is rated as good for the care of patients with long-term conditions.

Nationally reported Quality and Outcomes Framework (QOF) data (2014/15) showed the practice had achieved good outcomes in relation to the conditions commonly associated with this population group. For example, performance for chronic obstructive pulmonary disease (COPD) related indicators were above the national average (100% compared to 96% nationally).

Good



Summary of findings

The practice had a register of patient with long term conditions which they monitored closely for annual call and recall appointment for health checks. There were longer appointments available for these clinics. Extended opening hours and home visits were available when needed.

The clinical staff kept themselves updated with new guidance via educational meetings. There were dedicated chronic disease nurses and the GPs all had lead areas for example, COPD, asthma and diabetes.

Families, children and young people

The practice is rated as good for the care of families, children and young people.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. There were regular weekly safeguarding meetings at the practice on a Thursday which were part of the practice clinical meetings.

The practice reviewed children who had long term conditions every six months. There was a register of approximately 30-40 children. This included reviewing children with asthma, looking at number of admissions, inhalers and steroids prescribed. This had improved communication with secondary care and the practice awareness of these patients.

Immunisation rates were comparable with CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 72% to 100%, compared to the CCG averages of 85% to 99% and for five year olds from 90% to 99%, compared to CCG averages of 92% to 100%.

The practice's uptake for the cervical screening programme was 80%, which was slightly below the national average of 82%.

Appointments were available outside of school hours and the premises were suitable for children and babies. Mother and baby clinics were offered by the health visiting team at the Chichester Practice on Monday, Wednesday and Thursday. Child immunisations were carried out by making an appointment with the practice nurse.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

Good



Summary of findings

The practice was proactive in offering online services which included appointment booking, test results and ordering repeat prescriptions. There was a full range of health promotion and screening that reflected the needs for this age group.

Staff had been trained by Change for Life specialists to offer health advice and to sign post patients. This is an NHS organisation dedicated to the health and well-being of the public.

Flexible appointments were available as well as extended opening hours.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of 72 patients living in vulnerable circumstances. There was a nominated GP lead for learning disabilities and proactive booking of appointments for them with longer appointments offered.

The practice had close working relationship with the local drug and alcohol worker who consulted with patients at the practice with two nominated GPs who signed the prescriptions.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

There were alerts added to patient's records who had poor vision or hearing and staff knew to help them navigate through the appointment system. The practice had a homeless policy and specific pack available at reception for homeless patients.

The practice's computer system alerted GPs if a patient was a carer. There was a practice register of all people who were carers and were being supported, for example, by offering health checks and referral for social services support. There was a specific carers lead in the practice. There were 329 patients on the carer's register which was 2.65% of the practice population. Written information was available for carers to ensure they understood the various avenues of support available to them. Carer's packs were given to new patients and a young carers group was advertised in the waiting area. The practice had close links with the local carers organisation.

Good



Summary of findings

People experiencing poor mental health (including people with dementia)

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

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health.

The practice maintained a register of patients experiencing poor mental health and recalled them for regular reviews. The patients were proactively contacted by the GP who knows them best regarding their review appointment. They told them how to access various support groups and voluntary organisations. Following notification of the patient attending accident and emergency at the hospital, if felt appropriate, the GP would contact the patient.

Performance for mental health related indicators was better than national average. For example performance for dementia indicators was above the national average (100% compared to 94.5% nationally).

Good



Summary of findings

What people who use the service say

We spoke with five patients on the day of our inspection, which included a member of the practice's patient participation group (PPG).

Four of the patients were happy with the service they received from the practice. However, all five patients said it could be sometimes difficult to obtain a routine appointment.

We reviewed 22 CQC comment cards completed by patients prior to the inspection. 16 of the cards completed were wholly positive. Common words used to describe the practice included, very good, first class, and efficient, polite and helpful staff. Six of the cards had general concerns; however, there was no pattern to them.

The latest GP Patient Survey published in July 2016 showed that scores from patients were comparable to or slightly lower than national and local averages. The percentage of patients who described their overall experience as good was 87%, which was comparable to the local clinical commissioning group (CCG) average of 88% and the national average of 85%. Other results from those who responded were as follows;

- The proportion of patients who would recommend their GP surgery – 81% (local CCG average 79%, national average 78%).

- 90% said the GP was good at listening to them compared to the local CCG average of 91% and national average of 89%.
- 89% said the GP gave them enough time compared to the local CCG average of 89% and national average of 87%.
- 88% said the nurse was good at listening to them compared to the local CCG average of 92% and national average of 91%.
- 88% said the nurse gave them enough time compared to the local CCG average of 94% and national average of 92%.
- 70% said they found it easy to get through to this surgery by phone compared to the local CCG average 79%, national average 73%.
- 67% described their experience of making an appointment as good compared to the local CCG average 77%, national average 73%.
- Percentage of patients who find the receptionists at this surgery helpful – 86% (local CCG average 89%, national average 87%).

These results were based on 122 surveys that were returned from a total of 276 sent out; a response rate of 44% and less than 1% of the overall practice population.

Outstanding practice

- The practice was part of a frailty/multi-morbidity project. This involved identifying patients who were either palliative or housebound who had polypharmacy and three or more long term conditions. Polypharmacy is the use of four or more medications by a patient. A visit was arranged to see the patient and an advanced care plan was compiled.

Patients who had been seen so far in the project included 20 in nursing homes and 35 in their own home. This had resulted in medication reviews and as a result of this there were further investigations with referrals to the memory clinic, continence clinic and geriatric assessments.

Farnham Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and a specialist advisor with experience of GP practice management.

Background to Farnham Medical Centre

Farnham Medical Centre provides Primary Medical Services to the town of South Shields. Services are provided from two locations;

- Farnham Medical Centre, 435 Stanhope Road, South Shields, Tyne and Wear, NE33 4QY.
- Chichester Practice, Stanhope Parade Health Centre, Gordon Street, South Shields, Tyne and Wear, NE33 4JP

We visited both practices on the day of the inspection.

The practices have two separate General Medical Services (GMS) contracts with NHS England. We have provided a separate inspection report for Chichester Practice.

Farnham Medical Centre provides services to approximately 12,400 patients of all ages. The surgery is located in purpose built premises which have been extended over time to accommodate the needs of the practice. There is step free access at the front of the building and all facilities are on the ground floor with full disabled access. There is street car parking to the front of the surgery including dedicated disabled parking bays.

The practice has six GP partners and two salaried GPs. Four are female and four male. The practice is a training practice

which has GP trainees allocated to the practice (fully qualified doctors allocated to the practice as part of a three-year postgraduate general practice vocational training programme) and F2 doctors (a medical practitioner undertaking a medical training programme which forms the bridge between medical school and specialist/general practice training). There are two nurse practitioners (one who works in the winter months only) two practice nurses and two health care assistants. There is a practice manager and assistant practice manager. There are 18 members of administration staff and two cleaners. The staff work at both Farnham Medical Centre and Chichester Practice.

The practice is part of South Tyneside clinical commissioning group (CCG). Information taken from Public Health England placed the area in which the practice was located in the second most deprived decile. In general, people living in more deprived areas tend to have greater need for health services.

The practice is open weekday from 8am and until 6pm Tuesday, Wednesday and Friday. There are extended opening hours until 7:30pm Monday and Thursday evenings.

Consulting times with the GPs and nurses range from 8am – 12:30pm and 2.30pm – 6pm. On extended opening days consulting times run to 7:20pm.

The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and Vocare known locally as Northern Doctors Urgent Care Limited.

Why we carried out this inspection

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

Detailed findings

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included the local clinical commissioning group (CCG) and NHS England.

The inspection team:

- Reviewed information available to us from other organisations, for example, NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced inspection visit on 22 September 2016.
- Spoke with staff and patients.
- Looked at documents and information about how the practice was managed.
- Reviewed patient survey information, including the NHS GP Patient Survey.
- Reviewed a sample of the practice's policies and procedures.

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. The practice manager was responsible for their collation. They maintained a schedule of these, there had been seven in the last 12 months. Significant events were discussed at the practice clinical meeting and an annual review had recently taken place. The practice told us they were constantly improving the recording and investigation of significant events.

Staff we spoke with were aware of the significant event process and actions they needed to take if they were involved in an incident. They gave us examples of feedback from recent incidents. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance and national safety alerts. The practice manager managed the dissemination of national patient safety alerts with the assistance of two of the secretaries.

Overview of safety systems and processes

The practice could demonstrate a safe track record through having systems in place for safeguarding, health and safety, including infection control, and staffing.

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The practice had a safeguarding information board in the staff room with key contact information and general information regarding female genital mutilation, domestic abuse and an easy read guide to safeguarding.
- One of the practice GP partners was the lead for safeguarding adults and children, with a salaried GP as deputy. Patient records were tagged with alerts for staff if there were any safeguarding issues they needed to be aware of. There were regular weekly safeguarding meetings at the practice on a Thursday as part of the

practice clinical meetings. Community health care staff, for example, a health visitor and midwife attended the meetings. Staff demonstrated they understood their responsibilities and had all received safeguarding children training relevant to their role. Both safeguarding leads had received level three safeguarding children training.

- There was a notice displayed in the waiting area, advising patients that they could request a chaperone, if required. The practice nurses and some of the reception staff carried out this role. They had all received chaperone training. All staff who carried out chaperone duties had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy, patients commented positively on the cleanliness of the practice. One of the practice nurses was the infection control lead. There were infection control policies, including a needle stick injury policy. An infection control audit had been carried out in June 2016 and there were regular hand hygiene audits. Where actions were raised these had been addressed. A legionella risk assessment had been carried out in July 2016; the practice manager said the risks were minimal. We saw documentation to confirm this. However the contactor still had not forwarded the final report to the practice. This was being chased up by them.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording and handling.). Prescription pads were securely stored and there were systems in place to monitor their use. The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) pharmacist.

We saw the practice had a recruitment policy which was updated regularly. Recruitment checks were carried out. We sampled recruitment checks for both staff and GPs and saw that checks had been undertaken prior to

Are services safe?

employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate DBS checks. We saw that the clinical staff had medical indemnity insurance.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patients and staff safety. There was a health and safety policy and risk assessment. The practice manager told us that the practice had secured funding to install electronic doors at the entrance to the building to improve disabled access. The practice had fire risk assessments in place. A member of staff had been trained as fire warden and there were regular fire drills. Staff had received fire and health and safety training. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. There had been a recent asbestos risk assessment carried out.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice occasionally used locum cover. There were rotas in place for GP and administration staff cover.

Arrangements to deal with emergencies and major incidents

All staff received basic life support training and there were emergency medicines available in the practice. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location.

The practice had a business continuity plan in place for major incidents such as building damage. The plan included emergency contact numbers for staff and was updated on a regular basis.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The staff kept themselves up to date via weekly clinical and educational meetings and met every day for coffee to discuss and support each other on clinical issues. There were dedicated chronic disease nurses and the GPs all had lead areas for example, COPD, asthma and diabetes.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). The QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures. The results are published annually. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

The latest publicly available data from 2014/15 showed the practice had achieved 98.5% of the total number of points available to them, with a clinical exception reporting rate of 8.8%. The QOF score achieved by the practice in 2014/15 was above the England average of 94.8% and the local clinical commissioning group (CCG) average of 94.4%. The clinical exception rate was below the England average of 9.2% and the CCG average of 9.5%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

The data showed:

- Performance for chronic obstructive pulmonary disease (COPD) related indicators were above the national average (100% compared to 96% nationally). The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness in the preceding 12 months was 90.6% which was better than the national average of 89.9%.
- Performance for mental health related indicators was above the national average (98.1% compared to 92.8%

nationally). For example, 90.2% of patients with schizophrenia, bipolar affective disorder and other psychosis had a comprehensive agreed care plan documented within the preceding 12 months. This compared to a national average of 88.5%.

- Performance for dementia indicators was above the national average (100% compared to 94.5% nationally).
- Performance for asthma related indicators was better than the national average (100% compared to 97.4% nationally).
- Performance for diabetes related indicators was above the national average (94.5% compared to 89.2% nationally). For example, the percentage of patients on the diabetes register who had an influenza immunisation was 98.7%, compared to a national average of 94.5%.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. Some clinical audits were triggered following significant events. We saw a schedule of clinical audits which had been carried out which went back to 2014. We saw examples of several full completed audits which had been carried out in the last year. This included an audit to increase the screening of patients who were identified as being at risk of COPD. This was carried out across both practices. There was an overall improvement to how many patients were screened (33% to 77%).

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as fire safety, health and safety and responsibilities of their job role. There was also an up to date locum induction pack at the practice.
- The learning needs of non-clinical staff were identified through a system of appraisals and informal meetings. Staff had access to appropriate training to meet those learning needs and to cover the scope of their work. Non-clinical staff had received an appraisal within the last twelve months. We saw examples of these. Staff told us they felt supported in carrying out their duties. The practice nurses were appraised by one of the nurse practitioners.

Are services effective?

(for example, treatment is effective)

- All GPs in the practice had undertaken revalidation (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list.) The salaried GPs also received in house appraisals.
- Staff received training that included: fire and health and safety, equality and diversity, basic life support, safeguarding children and adults, prevent awareness, customer service and information governance awareness. Clinicians and practice nurses had completed training relevant to their role. Staff had been encouraged to study national vocational qualifications (NVQ) in business administration. The practice gave staff study time for this. The practice nurses attended a local forum and shared knowledge with other practice nurses.
- The practice is a training practice for trainee doctors. There were three GP trainers at the practice.

They taught third and fifth year medical students and supervised GP registrars and F2 doctors (a .

Coordinating patient care and information sharing

The practice had effective and well established systems to plan and deliver care and treatment. Patient information was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example, when people were referred to other services. All patients discharged from hospital and who were highlighted as at risk of medical admission were contacted within three days of discharge to ask if they needed any further support.

Staff worked together and with other health and social care services. Multi-disciplinary team meetings took place weekly as part of the practice clinical meeting.

The GPs and staff at the practice had links with other primary care and secondary care providers. They were in the process of establishing a federation. AGP federation is a group of GP practices that decide to collaborate to provide improved access and quality. The GPs were part of the local medical forum.

The practice carried out a review of their cancer diagnoses every six months to see if anything could have been done differently or improved for the patient.

The practice reviewed children who had long term conditions every six months. There was a register of approximately 30-40 children. This included reviewing children with asthma, looking at number of admissions, inhalers and steroids prescribed. This had improved communication with secondary care and the practice awareness of these patients.

The practice had a palliative care lead in the practice, a palliative register which was discussed at the weekly clinical meeting. There was a named and second GP for each patient on the register.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and recorded the outcome of the assessment. We saw an example of a consent form.

Health promotion and prevention

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

The practice had a cervical screening programme. The practice's uptake for the cervical screening programme was 80%, which was slightly below the national average of 82%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were in line with CCG/national averages. For example, childhood immunisation rates for the vaccinations given to

Are services effective?

(for example, treatment is effective)

under two year olds ranged from 72% to 100%, compared to the CCG averages of 85% to 99% and for five year olds from 90% to 99%, compared to CCG averages of 92% to 100%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients with the healthcare assistant or the GP or nurse if appropriate.

Staff had been trained by Change for Life specialists to offer health advice and to sign post patients. This is an NHS organisation dedicated to the health and well-being of the public. Follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that they were treated with dignity and respect.

- Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs.

We reviewed 22 CQC comment cards completed by patients prior to the inspection. 16 of the cards completed were wholly positive. Common words used to describe the practice included, very good, first class, and efficient, polite and helpful staff. Six of the cards had general concerns; however, there was no pattern to them. Four of the patients we spoke with were satisfied with the service they received from the practice.

Results from the National GP Patient Survey published in July 2016 showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The practice results were comparable with local and national satisfaction scores on consultations with doctors and nurses. For example, of those who responded:

- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 97% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and the national average of 97%.
- 86% said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us that they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had

sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the National GP Patient Survey showed patient's responses were comparable to local and national averages regarding their involvement in planning and making decisions about their care and treatment for GPs however scores were lower for nurses. For example, of those who responded:

- 90% said the GP was good at listening to them compared to the CCG average of 91% and the national average of 89%.
- 89% said the GP gave them enough time compared to the CCG average of 89% and the national average of 87%.
- 86% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.
- 88% said the last nurse they spoke to was good listening to them compared to the CCG average of 92% and the national average of 91%.
- 88% said the nurse gave them enough time compared to the CCG average of 94% and the national average of 92%.

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

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations and there was a good range of leaflet information available in the waiting area.

The practice's computer system alerted GPs if a patient was a carer. There was a practice register of all people who were carers and were being supported, for example, by offering health checks and referral for social services support. There was a specific carers lead in the practice. There were 329 patients on the carer's register which was 2.65% of the practice population. Written information was available for carers to ensure they understood the various avenues of support available to them. Carers packs were given to new patients and a young carers group was advertised in the waiting area. The practice had close links with the local carers organisation.

Are services caring?

The practice had a homeless policy and specific pack available at reception for homeless patients.

Staff told us that if families had suffered bereavement, depending upon the families wishes the GP would telephone or visit to offer support.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. Many of the staff had worked there for many years which enabled good continuity of care. The practice had close links with the local community through the different multi-disciplinary meetings and groups the practice attended.

The practice worked with the local clinical commissioning group (CCG) to improve outcomes for patients in the area. The practice were part of the better outcome scheme with the local CCG which looked at improvement in care for cancer, cardiovascular disease, chronic obstructive pulmonary disease (COPD) and patients and end of life care. The practice achieved maximum points from the CCG for this scheme.

The practice was part of a frailty/multi-morbidity project. This involved identifying patients who were either palliative or housebound who had polypharmacy, this is the use of four or more medications by a patient or where the patients and three or more long term conditions. A visit was arranged to see the patient and an advanced care plan was compiled. Patients who had been seen so far in the project included 20 in nursing homes and 35 in their own home. This had resulted in medication reviews and further investigations with referrals to the memory clinic, continence clinic and geriatric assessments.

The practice provided a dedicated GP to the three care homes which they provided services to. There were fortnightly 'ward rounds' at the care homes. There were reviews of all of these patients who had been discharged from hospital. The practice had also recently been awarded the contract to provide services to a newly opened re-enablement service.

The practice had a register of patients with long term conditions which they monitored closely for annual call and recall appointment for health checks. There were longer appointments available for these clinics.

There were alerts added to patient's records who had poor vision or hearing and staff knew to help them navigate through the appointment system.

Services were planned and delivered to take into account the needs of different patient groups and to help to provide flexibility, choice and continuity of care. For example;

- Telephone consultations were available if required
- Booking appointments with GPs and requesting repeat prescriptions was available online.
- Home visits were available for housebound patients or those who could not travel to the surgery.
- Specialist clinics were provided including minor surgery and contraceptive implants. The practice carried out travel vaccinations, which included yellow fever.
- One of the GP partners was a specialist in ear nose and throat (ENT) services. The practice had a contract to provide these services for all South Tyneside practices. On a Friday morning they ran a clinic for ear suction for patients whose ears could not be syringed. On a Friday afternoon they ran a full ENT clinic with an audiologist in attendance from the local hospital.
- The practice had close working relationship with the local drug and alcohol worker who consulted with patients at the practice with two nominated GPs who signed the prescriptions.
- There were disabled facilities, hearing loop and translation services available.
- All patient services were accessible to patients with physical disabilities. Other reasonable adjustments were made and action was taken to remove barriers when people found it hard to use or access services.
- Mother and baby clinics were offered by the health visiting team at the Chichester Practice on Monday, Wednesday and Thursday. Child immunisations were carried out by making an appointment with the practice nurse.

Access to the service

The practice was open weekday from 8am and until 6pm Tuesday Wednesday and Friday. There were extended opening hours until 7:30pm on Monday and Thursday evenings.

Consulting times with the GPs and nurses ranged from 8am – 12:30pm and 2.30pm – 6pm. On extended opening days consulting times ran to 7:20pm.

All five patients we spoke with said it could be sometimes difficult to obtain a routine appointment. We looked at the practice's appointments system in real-time on the

Are services responsive to people's needs?

(for example, to feedback?)

afternoon of the inspection. There were emergency appointments available in the evening surgery that day and the next routine appointment was available with either a nurse practitioner or GP within two working days.

Results from the National GP Patient Survey showed that patient's satisfaction with how they could access care and treatment were lower than local and national averages. For example;

- 76% of patients were satisfied with the practice's opening hours compared to the local CCG average of 81% and national average of 76%.
- 70% of patients said they could get through easily to the surgery by phone compared to the local CCG average of 79% and national average of 73%.
- 67% of patients described their experience of making an appointment as good compared to the local CCG average of 77% and national average of 73%.
- 56% of patients said they usually waited 15 minutes or less after their appointment time to be seen compared to the local CCG average of 74% and national average of 58%.

The practice were concerned with the satisfaction rates for patients experience of getting through to the surgery by phone, making an appointment and wait time for their consultation. They were also aware that there were several complaints regarding this. A new telephone system with more phone lines to the practice had been put in place from April 2016. The appointment system was also

reviewed and more appointments were made available. The practice planned to carry out a review of the changes in October 2016 to test their effectiveness. They had already noticed that complaints had reduced as a result.

Listening and learning from concerns and complaints

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

We saw the practice had received 39 complaints in the last 12 months, of which 20 were written and 19 verbal and these had been investigated in line with their complaints procedure. Most of the complaints related to how patients could get through on the phone to the practice or in relation to the appointment system. This had been addressed by the practice increasing the number of staff answering the telephones at busy periods and more appointments being made available. Complaints and lessons to be learned from them were discussed at clinical meetings. Where mistakes had been made, it was noted the practice had apologised formally to patients and taken action to ensure they were not repeated. However, there was no information for patients in these letters regarding taking the complaint further such as to NHS England or The Parliamentary and Health Service Ombudsman.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a vision which was to 'serve their patients by delivering a quality service to enable patients to receive best practice care and treatment'. They stated they would strive to promote the good health of all of their patients.

The practice had a practice five year development plan. This set out objectives of what they were trying to achieve over the next three to five years. For example, increase their list size by 2% and to maintain both premises and make them more suitable for patients with disabilities.

The practice also saw capacity and demand for appointments as a priority for the practice, this was in the development plan and they had carried out some work in this area which included an action plan that identified areas for improvement.

The staff we spoke with, including clinical and non-clinical staff, all knew the provision of high quality care for patients was the practice's main priority. They also knew what their responsibilities were in relation to this and how they played their part in delivering this for patients.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities, the GP partners were involved in the day to day running of the practice.
- There were clinical leads for areas such as safeguarding and information governance.
- Practice specific policies were implemented and were available to all staff.
- Managers had a comprehensive understanding of the performance of the practice.
- A programme of continuous clinical audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality

care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice. Staff told us that they were approachable and always took the time to listen to all members of staff.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.

There were multi-disciplinary clinical meetings held every week. A business meeting was held every month and there were regular practice meetings and nurse meetings, we saw comprehensive minutes of all of these meetings. There was a running log kept and a list of whatever actions came from the meetings with the outcome.

The practice manager told us the practice management team put staff health and well-being high on their list of priorities. They arranged a presentation to staff from Change for Life which is an NHS organisation dedicated to the health and well-being of the public. The practice had a health and well-being policy and had a notice board in the staff area dedicated to advice on this subject.

The practice knew their priorities they had plans in place for areas they needed to work on and knew in what areas they had improved.

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

The practice encouraged and valued feedback from patients. They had gathered feedback from patients through a patient survey and formal and informal complaints received and the practice participation group (PPG).

The practice had a patient participation group (PPG) with ten members who met quarterly. We spoke with a member of the PPG. They told us the practice were open to suggestions from the group. The group had discussed with the practice how they thought the appointments system could be improved. They also helped the practice design their new carers pack.

The practice had also gathered feedback from staff. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and

Are services well-led?

Good 

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

management. Opportunities for individual training were identified at appraisal. All staff were encouraged to identify opportunities for future improvements on how the practice was run. There were regular staff social events.

Continuous improvement

The GPs in the practice were involved in the setting up of a local federation of GP practices. (A Federation is a group of practices and primary care teams working together, sharing responsibility for developing and delivering high quality, patient focussed services for their local communities).

The practice had listened to patients and sought to improve their access to appointments. They were very keen to improve the process as well as they could and were to continually review this process.

The practice had considered supporting staff and patients to lead healthier lives by obtaining training and presentations from Change for Life.

The practice worked with the local clinical commissioning group (CCG) to improve outcomes for patients in the area. The practice were part of the better outcome scheme with the local CCG which looked at improvement in care for cancer, cardiovascular disease, chronic obstructive pulmonary disease (COPD) and patients and end of life care. The practice was part of a frailty/multi-morbidity project to improve elderly patient care. The practice provided a dedicated GP to the three care homes which they provided services to. There were fortnightly 'ward rounds' at the care homes. There were reviews of all of these patients who had been discharged from hospital. The practice had also recently been awarded the contract to provide services to a newly opened re-enablement service.

There was a focus on continuous learning and improvement within the practice. The practice had protected learning times once a month both at the practice and at CCG organised events. The practice was also a training practice.