Fulwell Medical Centre

Quality Report

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Date of inspection visit: 14 June 2016
Date of publication: 12/09/2016

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Fulwell Medical Centre on 14 June 2016. Overall, the practice is rated as good.

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

- There was an open and transparent approach to safety and a highly effective system for reporting and recording significant events. The staff team took the opportunity to learn from all internal and external incidents.
- Risks to patients and staff were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. They had the skills, knowledge and experience to deliver effective care and treatment. Action was being taken to address gaps identified in the practice's staff training plan.
- Outcomes for patients were consistently good. Data from the Quality and Outcomes Framework (QOF) showed that the practice's performance was above the local clinical commissioning group (CCG) and England averages in most of the indicators covered.
- There was a strong, visible, person-centred culture. Patients said they were treated with compassion, dignity and respect and that they were involved in decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Services were tailored to meet the needs of individual patients and were delivered in a way that ensured flexibility, choice and continuity of care. All staff were actively engaged in monitoring and improving quality and patient outcomes. Staff were committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion.

Summary of findings

- The leadership, governance and management of the practice assured the delivery of good quality person-centred care, supported learning, and promoted an open and fair culture.

However, there were also areas where the provider needs to make improvements. The provider should:

- Provide non-clinical staff with regular updates to their basic life support.
- Ensure staff identified in the practice's training plan complete outstanding mandatory training.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

There was a good system for reporting and recording significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned when things went wrong and shared with staff to support improvement. There was an effective system for dealing with safety alerts and sharing these with staff. The practice had clearly defined systems and processes that helped keep patients safe. Individual risks to patients had been assessed and were well managed. Good medicines management systems and processes were in place. The premises were clean and hygienic. Employment checks were usually carried out by the practice. However, on one occasion, this had not happened. The practice provided us with the required information shortly after the inspection.

Are services effective?

Good

The practice is rated as good for providing effective services.

Outcomes for patients were consistently good. Data from the Quality and Outcomes Framework (QOF) showed that the practice's performance was above the local clinical commissioning group (CCG) and England averages in most of the indicators covered. Patients' needs were assessed and care was planned and delivered in line with current evidence based guidance. Clinical audits were carried out to help improve patient outcomes. Staff were consistent in supporting patients to live healthier lives through a targeted and proactive approach to health promotion. This included providing advice and support to patients to help them manage their health and wellbeing. Staff worked effectively with other health and social care professionals to ensure the range and complexity of patients' needs were met. Staff had the skills, knowledge and experience to deliver effective care and treatment. Action was being taken to address gaps identified in the practice's staff training plan.

Are services caring?

Good

The practice is rated as good for providing caring services.

Staff treated patients with kindness and respect, and maintained patient and information confidentiality. Overall, patients we spoke with, and those who had completed a CQC comment card, were satisfied with the care and treatment they received. Data from the NHS National GP Patient Survey of the practice, published in January 2016, showed patient satisfaction levels with the quality of

Summary of findings

GP and nurse consultations, and their involvement in decision making, were either above, or broadly in line with, the local CCG and national averages. For example, 96% of patients said they had confidence and trust in the last GP they saw, or spoke to, compared with the local CCG and national averages of 95%. With regards to their involvement in decision making, 89% of patients said the last GP they saw, or spoke to, was good at involving them in decisions about their care, compared with the local CCG average of 83% and the national average of 82%. Information for patients about the range of services provided by the practice was available and easy to understand. Staff had made arrangements to help patients and their carers cope emotionally with their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Services were planned and delivered to take into account the needs of different patient groups and to provide flexibility, choice and continuity of care. Most of the patients we spoke with, or who completed Care Quality Commission (CQC) comment cards, raised no concerns about access to appointments. Results from the NHS GP Patient Survey of the practice, showed that patient satisfaction levels with telephone access and appointment availability was either above, or broadly in line with, the local CCG and national averages. For example, 95% of patients said the last appointment they got was convenient, compared with the local CCG and the national averages of 92%. Regarding access to appointments, 83% of patients said they were able to get an appointment to see, or speak to someone, the last time they tried. This was the same as the local CCG average and broadly in line with the national average of 85%. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. There was evidence the practice responded appropriately to any issues raised.

Are services well-led?

Good

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

The practice had good governance and performance management arrangements. They had clearly defined and embedded systems and processes that kept patients safe. There was a clear leadership structure and staff felt well supported by the GPs and the practice management team. Examples of good governance arrangements included the carrying out of evidence based assessments, the allocation of lead roles to staff to help promote good clinical leadership, and the holding of regular planned meetings to share information to manage patient risk. The practice actively sought feedback from patients via their Friends and Family Test survey and

Summary of findings

patient participation group. They had acted on this feedback by improving patients' access to same-day care and treatment. There was a very strong focus on, and commitment to, continuous learning and improvement at all levels within the practice.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

Nationally reported Quality and Outcomes Framework (QOF) data, for 2014/15, showed the practice had performed very well in relation to providing care and treatment for the clinical conditions commonly associated with this population group. For example, the practice had obtained 100% of the total points available to them, for providing care and treatment to patients who had heart failure. This was 1.3% above the local clinical commissioning group (CCG) average and 2.1% above the England average. The practice offered proactive, personalised care which met the needs of older patients. For example, all patients over 75 years of age had a named GP who was responsible for their care, and were invited to attend an annual healthcare review. Patients on the practice's housebound register were provided with an annual health review in their own home, to help make sure they had contact with the surgery, and were aware of how to access support services.

People with long term conditions

Good

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

Nationally reported QOF data, for 2014/15, showed the practice had performed well in relation to providing care and treatment for the clinical conditions commonly associated with this population group. For example, the practice had obtained 100% of the total points available to them, for providing care and treatment to patients with diabetes. This was 6.5% above the local CCG average and 10.8% above the England average. Staff were taking steps to improve the quality of support provided to diabetic patients. For example, one of the practice nurses had worked with a diabetic nursing specialist, and had completed additional training, to enable them to provide services closer to home for patients with diabetes. There was a multi-disciplinary team approach to managing long-term conditions, so that patients with several medical conditions did not have to attend the practice more often than necessary. The practice had a good 'call and recall' system, which helped ensure that all patients who needed a healthcare review received an invitation to attend. There was a designated lead GP and nurse for each of the main long-term conditions (LTCs.) This helped to ensure that

Summary of findings

information relating to the key LTCs was disseminated to the practice team. Arrangements had been made which helped to ensure that patients with LTCs received a pneumococcal vaccination.

Families, children and young people

Good

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

The practice had made good arrangements to meet the needs of children, families and younger patients. For example, community midwives ran a weekly antenatal clinic, and health visitors provided a weekly child health clinic. Appointments were available outside of school hours and the practice premises were suitable for children and babies. Plans were being made to invite the local primary care reception class to the practice, to provide guidance relating to healthy eating. The practice offered a full range of immunisations for children. Publicly available information showed they had performed very well in delivering childhood immunisations. For example, childhood immunisation rates for the vaccinations given to under two years old ranged from 96.4% to 98.8% (the local CCG averages were between 96.2% to 98.9%). For five year olds, the rates ranged from 96.6% to 98.9% (the local CCG averages were between 31.6% to 98.9%). The practice offered contraceptive and sexual health advice, and information was available about how to access specialist sexual health services. Nationally reported data showed the uptake of cervical screening was, at 80%, comparable with the national average of 81.7%. There were good systems in place to protect children who were at risk and living in disadvantaged circumstances. All clinical staff had completed safeguarding training that was relevant to their roles and responsibilities.

Working age people (including those recently retired and students)

Good

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

The practice was proactive in offering online services, as well as a full range of health promotion and screening that reflected the needs of this group of patients. Nationally reported data showed the practice had performed well in providing recommended care and treatment to this group of patients. For example, the QOF data, for 2014/15, showed the practice had obtained 100% of the overall points available to them for providing care and treatment to patients who had hypertension. This was 0.5% above the local CCG average and 2.2% above the England average. Extended hours

Summary of findings

appointments were provided one day a week, to help working patients access suitable appointments. Information on the practice's website, and on display in their patient waiting area, directed patients to the out-of-hours service.

People whose circumstances may make them vulnerable

Good

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

There were good arrangements for meeting the needs of vulnerable patients and those who were nearing the end of their lives. There were also good systems in place to help reduce the number of emergency admissions to hospital. The practice maintained a register of patients with learning disabilities which they used to ensure they received an annual healthcare review. Extended appointments were offered to enable this to happen. The nursing team also carried out these reviews in patients' own homes, to help alleviate any anxiety. Most staff had completed training to become dementia friends, and clinical staff carried out opportunistic screening, to help ensure patients received appropriate care and treatment. Housebound patients without a diagnosed long-term condition also had access to an annual review. Good arrangements had been made to meet the needs of patients who were also carers. The practice maintained a carers' register and used this to provide these patients with access to care, treatment and support. Systems were in place to protect vulnerable children from harm. Staff understood their responsibilities regarding information sharing and the documentation of safeguarding concerns.

People experiencing poor mental health (including people with dementia)

Good

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

The practice had made good arrangements for meeting the needs of patients with mental health conditions. Nationally reported data, from the QOF for 2014/15, showed the practice had performed well in obtaining 100% of the total points available to them, for providing recommended care and treatment to this group of patients. The data showed that the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses, who had had a comprehensive care plan documented in their records, in the preceding 12 months, was good by comparision to other practices, (93.1% compared to the national average of 86.9%). Patients experiencing poor mental health were provided with advice about

how to access various support groups and voluntary organisations. Practitioners from the local community mental health team ran twice weekly clinics at the surgery, for patients with a variety of mental health needs.

There were also good arrangements in place for meeting the needs of patients who had dementia. The QOF data showed the practice had performed well in obtaining 100% of the total points available to them, for providing recommended care and treatment to this group of patients. However, the practice's performance, regarding the carrying out face-to-face reviews of patients diagnosed with dementia, was lower, at 74.4%, than the national average of 84%. Staff kept a register of these patients, and the practice's clinical IT system clearly identified them to help make sure clinical staff were aware of their specific needs. Clinical staff actively carried out opportunistic dementia screening, to help ensure their patients were receiving the care and support they needed to stay healthy and safe. Some staff acted as Dementia Friends, and most staff had attended dementia awareness training, to help them understand the needs of these patients and improve the care they received at the practice.

Summary of findings

What people who use the service say

Feedback from patients was positive about the way staff treated them. We spoke with three patients from the practice's patient participation group. They told us they were treated with compassion, dignity and respect, and felt well looked after. However, one person told us they sometimes found it difficult to obtain an appointment and see their preferred GP. As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received 42 completed comment cards which were all positive about the standard of care provided. Words used to describe the service included: excellent; good; professional; helpful; first class service; respectful and kind. However, four patients commented that it was difficult to obtain a suitable appointment. Two patients commented that appointment waiting times were too long and one said that they sometimes found it difficult to see their preferred doctor.

Data from the NHS National GP Patient Survey of the practice, published in January 2016, showed patient satisfaction levels with the quality of GP and nurse consultations, telephone access and appointment availability, were either above, or broadly in line with, the local clinical commissioning group (CCG) and national averages. For example, of the patients who responded to the survey:

- 96% had confidence and trust in the last GP they saw, compared to the local CCG and national averages of 95%.
- 93% said the last GP they saw was good at listening to them, compared to the local CCG average of 90% and the national average of 89%.
- 100% had confidence and trust in the last nurse they saw, compared to the local CCG average of 98% and the national average of 97%.
- 94% said the last nurse they saw was good at listening to them. This was the same as the local CCG average and above the national average of 91%.
- 95% said the last appointment they got was convenient, compared to the local CCG average of 94% and the national average of 92%.
- 83% were able to get an appointment to see or speak to someone the last time they tried. This was the same as the local CCG average and just below the national average of 85%.
- 76% found it easy to get through to the surgery by telephone, compared to the local CCG average of 78% and the national average of 73%.

  (250 surveys were sent out. There were 120 responses which was a response rate of 48%. This equated to 1.2% of the practice population.)

Areas for improvement

Action the service SHOULD take to improve

- Provide non-clinical staff with regular updates to their basic life support.
- Ensure staff identified in the practice's training plan complete outstanding mandatory training.

Fulwell 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 adviser and a practice professional with experience of general practice management. A member of the Care Quality Commission's Learning Academy team also attended the inspection as an observer.

Background to Fulwell Medical Centre

Fulwell Medical Centre provides care and treatment to 9,558 patients of all ages, based on a General Medical Services (GMS) contract. The practice is part of the NHS Sunderland clinical commissioning group (CCG) and provides care and treatment to patients living in the Fulwell area of Sunderland. We visited the following location as part of inspection: Fulwell Medical Centre, Ebdon Lane, Fulwell, Sunderland, SR6 8DZ.

The practice had a mostly white British population, with high numbers of older people and families. There were lower levels of significant social deprivation, drug and alcohol problems. Nationally reported data showed the practice had a significantly higher prevalence rate for many of the key chronic diseases when compared to the national averages. National data showed that 1.1% of the population are from an Asian ethnic minority background.

The practice was located in a purpose built building. There were four GP partners (one male and three female), four salaried GPs (all female), three practice nurses, including two nurse prescribers (all female). There were three healthcare assistants (female), a practice manager, a deputy practice manager and a large team of administrative and reception staff.

The practice is open Monday, Tuesday, Thursday and Friday between 8:30am and 6pm, and on a Wednesday between 7am and 6pm. The practice is closed at weekends.

GP appointment times: Monday, Tuesday, Thursday and Friday between 8:30am and 5:50pm and on a Wednesday between 7am and 5:50pm.

When the practice is closed patients can access out-of-hours care via the Northern Doctors Urgent Care Limited On-Call service, and the NHS 111 service.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008, as part of our regulatory functions. 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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 14 June 2016. During our visit we:

- Spoke with a range of staff, including three GPs, the practice manager, a practice nurse and some administrative staff. We also spoke with three members of the practice's patient participation group.
- Observed how patients were being cared for.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events and incidents. There was an agreed process for handling incidents, which had been introduced following the appointment of the practice manager. This included a template for recording details of the incident and how it had been dealt with. Learning from incidents was shared with staff during monthly multi-disciplinary team (MDT) meetings, as well as through MDT meeting minutes and the use of electronic web notes via the practice's intranet system. We saw evidence of improvement as a result of a reported incident which had led staff to actively review the needs of patients nearing the end of their life.

There were good arrangements for identifying, reporting, and learning from significant events. Staff had identified and reported on eight events during the previous 12 months. We found that, following each incident, staff had completed a significant event analysis (SEA) form. These provided details of what had happened, what staff had done in response and what had been learnt as a consequence. The sample of records we looked at, and evidence obtained from interviews with staff, showed the practice had managed such events consistently and appropriately. Learning had been disseminated and discussed during the practice's clinical meetings. The practice's approach to the handling and reporting of significant events ensured that the provider complied with their responsibilities under the Duty of Candour regulation. (The Duty of Candour regulation is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.)

The practice had a good system for responding to safety alerts which included a protocol setting out how staff should handle alerts. Staff recorded details of any alerts received on a tracking spreadsheet, which included details of actions taken. Any alerts received were also discussed during the monthly multi-disciplinary meetings, to make sure staff were made aware of any actions that needed to be undertaken.

Where relevant, patient safety incidents had been reported to the local clinical commissioning group (CCG) via the Safeguard Incident and Risk Management System (SIRMS). (This system enables GPs to flag up any issues via their surgery computer, to a central monitoring system, so that the local CCG can identify any trends and areas for improvement.)

Overview of safety systems and processes

The practice had a range of systems and processes in place which helped to keep patients and staff safe and free from harm. The practice had policies and procedures for safeguarding children and vulnerable adults. Staff told us they were able to easily access these. Safeguarding information was also available in the consultation rooms, for ease of access. A designated member of the GP team acted as the children and vulnerable adults safeguarding lead, providing advice and guidance to their colleagues. Staff demonstrated they understood their safeguarding responsibilities, to protect vulnerable children and adults. Children at risk, and vulnerable adults, were clearly identified on the practice's clinical IT system, to ensure clinical staff took this into account during consultations. Quarterly MDT meetings involving the whole primary care team were held to monitor vulnerable children and share information about risks. Arrangements had been made for designated staff to review the register held of at-risk children and vulnerable families, so that clinicians had access to accurate information about risk. Staff had received safeguarding training relevant to their role. For example, the GPs had completed level three child protection training.

The practice's chaperone arrangements helped to protect patients from harm. All the staff who acted as chaperones (the nurses and healthcare assistants), were trained for the role and had undergone 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.) The chaperone service was advertised on a poster displayed in the waiting area, and reference to the provision of a chaperone was recorded in the patient's clinical record.

Monitoring risks to patients

There were procedures for monitoring and managing risks to patients and staff safety. For example, the practice had carried out a health and safety risk assessment of the premises in July 2015. In addition to this, staff had also completed an additional health and safety toolkit, to help

them assess any potential risks. The practice had arranged for all clinical equipment to be serviced and calibrated, to ensure it was safe and in good working order. A range of other routine safety checks had also been carried out. These included checks of fire, electrical and gas systems, and the completion of an up-to-date fire risk assessment. A recent fire drill had been held.

Appropriate standards of cleanliness and hygiene were being maintained. The practice had a designated infection control lead, who had completed additional training to help them carry out this role effectively. However, two staff in the sample of training records we checked had not completed infection control training. There were infection control protocols in place and these could be easily accessed by staff. Sharps bin receptacles were available in the consultation rooms and those we looked at had been signed and dated by the assembler. Clinical waste was appropriately handled. An infection control audit had been carried out in February 2016, to identify whether any action was needed to reduce the risk of the spread of infection. We were told the outcome of the audit had not yet been discussed within an MDT setting. The practice manager acknowledged that this needed to be actioned promptly and agreed to address this following the inspection. A legionella risk assessment had been carried out with no actions identified. Checks of the water system had last been completed in December 2015 by external contractors. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.)

The arrangements for managing medicines, including emergency drugs and vaccines, helped to keep patients safe. There was a good system for monitoring repeat prescriptions and carrying out medicines reviews. Prescription pads were securely stored to reduce the risk of mis-use or theft. Suitable arrangements had been made to store and monitor vaccines. These included carrying out daily temperature checks of the vaccine refrigerators and keeping appropriate records. Patient Group Directions (PGD) had been adopted by the practice, to enable nurses to administer medicines in line with legislation. These were up-to-date and had been signed. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.) Appropriate systems were in place to manage high risk medicines. The practice had a medicines optimisation plan, to help them carry out safe, effective and evidence-based prescribing within agreed local pathways.

Required employment checks had been carried out for most staff recently appointed by the practice. We looked at a sample of five staff recruitment files. The practice had completed a Disclosure and Barring Service (DBS) check on each person. Checks had been carried out to make sure that clinical staff continued to be registered with their professional regulatory body. Appropriate indemnity cover was in place for all clinical staff. Written references had been obtained for three staff and they were not required for one person. However, the recruitment file for one member of staff contained no record of their employment history and no documentary evidence of their qualifications. The senior GP partner told us they had not asked for proof of this person's identity or written references, because they had known this person for over 30 years, and had collaborated with them professionally during this time. We were provided with information shortly after the inspection confirming that written references had been obtained for this person, as well as details of their employment history. Although there was no evidence in the recruitment files for some staff that proof of their identity had been obtained, all had undergone identity checks as part of the application process for obtaining a NHS SMART Card. The new practice manager had already identified that documentary proof of identity was required.

There were suitable arrangements for planning and monitoring the number and mix of staff required to meet patients' needs. Protocols had been put in place, to help ensure that there was a consistent approach to covering staff absence and vacant posts. These included the use of rotas to make sure there were sufficient numbers of clinical and non-clinical staff rostered on duty. The practice had a full complement of administrative and nursing staff. However, there had been a number of recent changes to the composition of the GP team, which had resulted in NHS England allowing the practice to temporarily close its patient list. Action had been taken to recruit additional staff. This included employing an experienced senior GP to cover clinical sessions on a long-term locum basis. Steps had been taken to recruit a fixed term, salaried GP and interviews were due to take place shortly. The practice had applied to host GPs participating in the 'Career Start GP' scheme, which aims to develop clinicians' clinical and

Good

Are services safe?

leadership skills. Steps were being taken to develop the role of a nurse practitioner, to deal with minor ailments and help triage telephone calls. A pharmacist had been employed to help with the practice's medicines management workload.

Arrangements to deal with emergencies and major incidents

The practice had made arrangements to deal with emergencies and major incidents. For example, there was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. Staff had completed basic life support training. However, the training records we sampled showed non-clinical staff had not received annual training. Advice from the Resuscitation Council (UK) states that non-clinical staff should have annual updates. Where the CPR training for some non-clinical staff had just expired, we saw appropriate training had been arranged.

Emergency medicines were available in the practice. These were kept in a secure area and staff knew of their location. All of the emergency medicines we checked were within their expiry dates. Staff also had access to a defibrillator as well as adult and children's face masks. Oxygen for use in an emergency was also available. Regular checks of the defibrillator had been carried out and a log of these had been kept.

The practice had a business continuity plan in place for major incidents, such as power failure or building damage. This was accessible to all staff via the practice's intranet system. A copy of the plan was also kept off site by key individuals. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff 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 practice had systems in place to keep all clinical staff up-to-date with new guidelines. For example, staff were actively following the latest NICE guidance on the wider use of statins to help prevent cardiovascular disease, through their use of a recommended risk calculator to identify at-risk patients. GP and nursing staff undertook lead roles for the main chronic diseases, to help provide their colleagues with leadership, disseminate information and make sure that patients received appropriate care and treatment.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF), and their performance against national screening programmes, to monitor and improve outcomes for patients. These outcomes were consistently very good. (QOF is intended to improve the quality of general practice and reward good practice).

The QOF data, for 2014/15, showed the practice had performed very well in obtaining 99.9% of the total points available to them for providing recommended care and treatment, with a 14% exception reporting rate. The reporting rate was 3.2% above the local clinical commissioning group (CCG) average and 4.8% above the England average. (The QOF scheme includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.)

We discussed the practice's high exception reporting rate with staff. We found the practice had a good patient 'call and recall' system in place. The practice employed a designated member of staff who worked solely on managing the practice's 'call and recall' system. There was an agreed comprehensive schedule in place to help staff monitor their QOF caseload. This included regular meetings to review the practice's performance and agree improvement actions for the month ahead. Before patients were 'excepted', clinical staff carried out a final check to determine whether any other action was needed clinically. Patients were only 'excepted' following this final check. Work was underway to introduce a new electronic patient recall system, to help make the practice's 'call and recall' system more effective. Nationally reported data analysed by CQC showed the practice's performance in relation to carrying out reviews of patients with specified mental health needs, and those diagnosed with dementia, was comparable with other practices. We found that unpublished QOF data to the year end, March 2016, showed a reduction in the practice's exemption reporting rate.

Examples of good QOF performance included the practice obtaining:

- 100% of the total points available to them, for providing recommended clinical care to patients who had cancer. This was 0.7% above the local CCG average and 2.1% above the England average.
- 100% of the total points available to them, for providing recommended clinical care to patients who had asthma. This was 2.9% above the local CCG average and 2.6% above the England average.
- 100% of the total points available to them for providing recommended clinical care to patients diagnosed with a stroke or transient ischaemic attack. This was 2% above the local CCG average and 3.4% above the England average.

Staff were proactive in carrying out clinical audits to help improve patient outcomes. We looked at two of the full clinical audits that had been carried out in the previous three years. These were relevant, showed learning points and evidence of changes to practice. The audits were also clearly linked to areas where staff had reviewed the practice's performance and judged that improvements could be made. For example, one of the GPs had identified that the practice did not have a protocol for monitoring the blood of patients prescribed enzyme-inducing antiepileptic drugs (AEDs). They had identified that the NICE guidelines recommended that patients taking AEDs should undergo a range of tests every two to five years. In the first cycle of the audit, staff had identified that there were a small number of patients who met this criteria who had not undergone these checks. Arrangements were made to review the needs of these patients and provide them with appropriate treatment. The second cycle of the audit showed there had

Good

Are services effective?

(for example, treatment is effective)

been an improvement in the numbers of patients prescribed AEDs receiving the recommended blood checks. Following the completion of the full audit cycle, epilepsy guidelines had been devised and shared with the practice team. The epilepsy template used by staff to record the outcome of their assessment and care planning had been amended to include a prompt to remind staff to check that patients prescribed AEDs had had their blood monitored during the previous five years.

Staff had also carried out a full cycle audit to identify patients who had been prescribed dementia medicines but who had not been added to the practice's dementia register. Failure to be included on the practice's register meant these patients had not received an invite to attend an annual healthcare review. Over the course of the full audit cycle, 23 patients had been identified following which their needs had been reviewed to ensure they were receiving appropriate care and treatment. The practice had shared the outcome of this audit with the local CCG dementia lead, and the CCG had adopted their audit process, as part of their dementia toolkit to be used by other practices.

Staff had carried out a range of medicine related audits, to help ensure prescribing was in line with best practice guidelines. They had also carried out a range of quality improvement audits, including audits of minor surgery, cervical screening, infection control, the defibrillator and vaccine refrigeration arrangements. The practice actively shared audit outcomes with other practices within their locality.

Effective staffing

Staff had the skills, knowledge and experience needed to deliver effective care and treatment. This included role-specific training as well as training in basic life support. Staff made use of e-learning training modules and in-house training to help them keep up-to-date with their mandatory training. However, when we sampled the training information for seven staff, we identified small gaps in some staff's training in fire safety, infection control and health and safety. The new practice manager had prepared a training plan in which they had identified gaps in some staff's training. They were taking action to address this.

Nursing staff had completed additional post qualification training to help them meet the needs of patients with long-term conditions. For example, one practice nurse was receiving support to develop their clinical skills, to take on a nurse practitioner role. Another nurse had completed an accredited course, and worked alongside a specialist community nurse, to help them initiate and manage injectable therapies for patients with Type 2 Diabetes. Two of the practice nurses had completed initial training and two-yearly updates, to enable them to provide immunisations for yellow fever. Healthcare assistants (HCAs) had received training that enabled them to carry out an enhanced role at the practice. For example, two of the HCAs had completed phlebotomy training and obtained certificates of competence, and all three were in the process of completing the Care Certificate training course.

Most staff whose files we checked had received an annual appraisal of their performance during the previous 12 months. A member of the nursing team told us they felt supported and had good access to good clinical peer support and oversight at the practice. Appropriate arrangements were in place to ensure the GPs received support to undergo revalidation with the General Medical Council.

Coordinating patient care and information sharing

The practice's patient clinical record and intranet systems helped to make sure staff had the information they needed to plan and deliver care and treatment. The practice had systems which enabled it to receive patient information electronically. For example, staff had electronic access to all lab and hospital results and records, and received hospital discharge summaries electronically. Staff shared NHS patient information leaflets, and other forms of guidance, with patients to help them manage their long-term conditions. All relevant information was shared with other services, such as hospitals, in a timely way. Important information about the needs of vulnerable patients was shared with the out-of-hours and emergency services, to help promote continuity of care. Staff worked well together, and with other health and social care professionals, to meet the range and complexity of patients' needs and to assess and plan on-going care and treatment.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of the legislation and guidance, including the Mental Capacity Act

Good

Are services effective?

(for example, treatment is effective)

(MCA, 2005). When staff provided care and treatment to young people, or adult patients whose mental capacity to consent was unclear, they carried out appropriate assessments of their capacity and recorded the outcome. Substantive clinical staff had completed MCA training, and had recently made a decision to use the MCA assessment tool on the practice's intranet system, to help improve record keeping. The locum GP had been asked by the practice to provide evidence they had completed MCA training.

Supporting patients to live healthier lives

Staff were committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion. Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged between 40 and 74 years. There were suitable arrangements for making sure a clinician followed up any abnormalities or risks identified during these checks. Health promotion links were available on the practice's website and on a screen in the patient waiting area.

The practice had a comprehensive screening programme. For example, the QOF data showed they had performed well by obtaining 100% of the overall points available to them, for providing cervical screening services. This was 1.3% above the local CCG average and 2.4% above the England average. The uptake of cervical screening was, at 80%, comparable with the national average of 81.7%. The practice also had protocols for the management of cervical screening, and for informing women of the results of these tests. These protocols were in line with national guidance. The practice had also performed well by obtaining 100% of the overall points available to them, for providing contraceptive services to women in 2014/15. This was 3.9% above the local CCG and the England averages. Patients were also supported to stop smoking. The QOF data showed that, of those patients aged over 15 years who smoked, 90.2% had been offered support and treatment during the preceding 24 months. This was 6.2% above the local CCG average and 4.9% above the England average. The data also confirmed the practice had supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy.

The practice offered a full range of immunisations for children. Publicly available information showed they had performed very well in delivering childhood immunisations. Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two years old ranged from 96.4% to 98.8% (the local CCG averages were between 96.2% to 98.9%). For five year olds, the rates ranged from 96.6% to 98.9% (the local CCG averages were between 31.6% to 98.9%).

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Throughout the inspection staff were courteous and helpful to patients who attended the practice or contacted it by telephone. We saw that patients were treated with dignity and respect. Privacy screens were provided in consulting rooms so that patients' privacy and dignity could be maintained during examinations and treatments. Consultation and treatment room doors were closed during consultations, so that conversations could not be overheard. Reception staff said that a private area would be found if patients needed to discuss a confidential matter. Information about this had been posted in the patient waiting area.

Feedback from patients was positive about the way staff treated them. We spoke with three patients from the practice's patient participation group. They told us they were treated with compassion, dignity and respect, and felt well looked after. However, one person told us they sometimes found it difficult to obtain a suitable appointment and see their preferred GP. As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received 42 completed comment cards and these were all positive about the standard of care provided. Words used to describe the service included: excellent; good; professional; helpful; first class service; respectful and kind. However, four patients commented that it was difficult to obtain a suitable appointment. Two patients commented that appointment waiting times were too long and one said that they sometimes found it difficult to see their preferred doctor.

Data from the NHS National GP Patient Survey of the practice, published in January 2016, showed patient satisfaction levels with the quality of GP and nurse consultations, telephone access and appointment availability, were either above, or broadly in line with, the local clinical commissioning group (CCG) and national averages. For example, of the patients who responded to the survey:

- 96% had confidence and trust in the last GP they saw, compared to the local CCG and national averages of 95%.
- 93% said the last GP they saw was good at listening to them, compared to the local CCG average of 90% and the national average of 89%.
- 91% said the last GP they saw or spoke to was good at giving them enough time, compared to the local CCG average of 88% and the national average of 87%.
- 100% had confidence and trust in the last nurse they saw, compared to the local CCG average of 98% and the national average of 97%.
- 94% said the last nurse they saw was good at listening to them. This was the same as the local CCG average and above the national average of 91%.
- 95% said the last nurse they saw or spoke to was good at giving them enough time. This was the same as the local CCG average and above the national average of 92%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with, and those who commented on this in their CQC comment cards, told us they were involved in decisions about their care and treatment. Results from the NHS GP Patient Survey of the practice showed patient satisfaction levels regarding involvement in decision-making were either above, or broadly in line with, the local CCG and national averages. Of the patients who responded to the survey:

- 90% said the last GP they saw was good at explaining tests and treatments, compared to the local CCG average of 88% and the national average of 86%.
- 89% said the last GP they saw was good at involving them in decisions about their care, compared to the local CCG average of 83% and the national average of 82%.
- 89% said the last nurse they saw was good at explaining tests and treatments, compared to the local CCG average of 93% and the national average of 90%.
- 88% said the last nurse they saw was good at involving them in decisions about their care, compared to the local CCG average of 89% and the national average of 85%.

Patient and carer support to cope emotionally with care and treatment

Staff were good at helping patients and their carers to cope emotionally with their care and treatment. They understood patients' social needs, supported them to

Good

Are services caring?

manage their own health and care, and helped them maintain their independence. Notices in the patient waiting room told patients how to access a range of support groups and organisations. We were told where patients had experienced bereavement, clinical staff would offer condolences and support in line with patients' wishes.

The practice was committed to supporting patients who were also carers. Staff maintained a register of these patients, to help make sure they received appropriate support, such as an annual healthcare review. There were 172 patients on this register, which equated to 1.8% of the practice's population. The practice's IT system alerted clinical staff if a patient was also a carer, so this could be taken into account when planning their care and treatment. Written information was available for carers to ensure they understood the various avenues of support available to them. The local Carers' Association had attended some influenza vaccination clinics, and provided an information stall where people could obtain information about the range of support services available to patients who were also carers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were planned and delivered to take into account the needs of different patient groups and to provide flexibility, choice and continuity of care. Examples of the practice being responsive to, and meeting patients' needs included:

- Providing all patients over 75 years of age with a named GP who was responsible for their care. Patients on the practice's housebound register were provided with an annual health review, to help make sure they had contact with the surgery, and were aware of how to access support services. The practice's nurses administered the annual influenza vaccination, and other relevant vaccinations, to housebound patients, if they had not been administered by the district nursing team. Age UK were invited to attend the practice's Saturday morning influenza clinics, to provide information and support. They also had a designated notice board at the practice, to help keep older patients up-to-date with the support services available to them.
- A multi-disciplinary team approach to managing long-term conditions (LTCs), so that patients with several medical conditions did not have to attend the practice more often than necessary. The practice had a good 'call and recall' system, which helped ensure that all patients who needed a healthcare review received an invitation to attend. There was a designated lead GP and nurse for each of the main LTCs. This helped to ensure that information relating to the key LTCs was disseminated to the practice team. In addition to providing in-house LTCs clinics, the practice nurses also visited housebound patients with chronic needs, including those living in care homes. The practice had signed up to the local Admissions Avoidance Scheme, to help reduce unplanned admissions into hospital. Staff had identified those patients with the most complex healthcare needs, and put care plans in place to meet their needs. Regular monthly meetings took place to review the needs of these patients. Patients discharged from hospital were contacted, so their needs could be reviewed and their care plans updated if necessary.
- Making good arrangements to meet the needs of children, families and younger patients. For example, the community midwives ran a weekly antenatal clinic, and health visitors provided a weekly child health clinic. A full programme of childhood immunisations was offered by the practice nursing team, and nationally reported data showed the practice had performed well in delivering these. Staff actively encouraged parents to attend immunisation appointments and, where children missed these, there was a system which ensured a nurse followed these up. Appointments were available outside of school hours and the practice premises were suitable for children and babies. Plans were being made to invite the local primary care reception class to the practice, to provide guidance relating to healthy eating. The practice offered a wide range of contraceptive services, and information was available at the practice about how to access specialist sexual health services.
- Good arrangements for meeting the needs of patients with mental health conditions. Nationally reported data, from the QOF for 2014/15, showed the practice had performed well in obtaining 100% of the total points available to them, for providing recommended care and treatment to this group of patients. The data showed that the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses, who had had a comprehensive care plan documented in their records in the preceding 12 months, was higher when compared to other practices, (93.1% compared to the national average of 86.9%). The practice had a co-ordinated 'one stop shop' approach to carrying out mental health reviews. Patients were first seen by a nurse so that any required tests could be carried out, followed immediately by a GP consultation. Clinical staff reviewed the records of patients who failed to attend their annual health review, to determine whether any further action was needed. Patients experiencing poor mental health were provided with advice about how to access various support groups and voluntary organisations. Practitioners from the local community mental health team ran twice weekly clinics at the surgery, for patients with a variety of mental health needs.
- Good arrangements for meeting the needs of patients who had dementia. The QOF data showed the practice had performed well in obtaining 100% of the total points available to them, for providing recommended care and treatment to this group of patients. The data showed the practice's performance regarding the

carrying out of face-to-face reviews of patients diagnosed with dementia, was comparable to other practices, (74.4% compared to the national average of 84%). Staff kept a register of patients who had dementia, and the practice's clinical IT system clearly identified them to help make sure clinical staff were aware of their specific needs. Clinical staff actively carried out opportunistic dementia screening, to help ensure patients aged over 60, were receiving the care and support they needed to stay healthy and safe. Some staff acted as Dementia Friends, and most staff had attended dementia awareness training, to help them understand the needs of these patients and improve the care they received at the practice. The practice had taken part in the local clinical commissioning group's dementia audit in 2015/16 and had, as a result of their involvement, introduced dementia friendly door signage, and contrasting coloured toilet seats and entrance mats.

- Good arrangements for meeting the needs of working age patients. For example, the nursing team offered a range of health promotion clinics, including NHS health checks for patients aged 40-75 years and smoking cessation clinics. The nursing team also coordinated the catch up vaccination campaigns, such as the meningitis immunisation for university entrants. Staff provided a Saturday morning influenza clinic every weekend in October, to help working patients access this service. Extended hours appointments were offered, with the practice opening at 7am each Wednesday. Patients were able to use on-line services to access appointments, request prescriptions and access their medical records. The practice ran a minor surgery service for patients with basic dermatological lesions, so that they could receive care and treatment closer to home.

- Making reasonable adjustments to help patients with disabilities, and those whose first language was not English, access the practice. All consultation and treatment rooms were located on the here was a disabled toilet which had appropriate aids and adaptations. Disabled parking was available and there were automatic doors into the practice. However, we saw the sloped ramp providing access to the entrance, could be difficult for wheelchair users to negotiate. Staff had access to a telephone translation service and interpreters should they be needed. Information on the practice's website encouraged patients to contact staff and tell them about any communication needs they had. A loop system was available for patients with hearing impairments. The practice provided patients who had learning disabilities with access to an extended annual review to help make sure they received the healthcare support they needed. Nurses also undertook these reviews in patients' own homes, to help alleviate any anxiety.

Access to the service

The practice was open Monday, Tuesday, Thursday and Friday between 8:30am and 6pm, and on Wednesdays between 7am and 6pm. Early morning appointments were available with the GPs, nurses and healthcare assistants. The practice was closed at weekends.

GP appointment times on Monday, Tuesday, Thursday and Friday were between 8:30am and 5:50pm and on a Wednesday between 7am and 5:50pm.

All consultations were by appointment only and could be booked by telephone, in person or on-line. Patients were able to access same day appointments, as well as routine pre-bookable appointments up to six weeks in advance. Patients contacting the practice to request urgent same-day care were triaged by the on-call GP, to determine the best response to their needs. Telephone consultations were also provided. Where appropriate, additional appointments were made available at the end of morning and afternoon surgeries, to help meet the demand for same-day urgent appointments. The nursing team held a daily minor ailments surgery each morning, to help provide patients with prompt access to appointments. On checking the appointment system at 3:15pm, we found same day appointments were still available, and that the next routine appointment with a GP was available within 48 hours.

The majority of the 42 patients who completed CQC comment cards raised no concerns about access to appointments. However, four patients commented that it was difficult to obtain a suitable appointment. Two patients commented that appointment waiting times were too long and one said that they sometimes found it difficult to see their preferred doctor. The practice had recently carried out an in-house patient survey, and produced an action plan to address the issues raised. Some respondents had reported that it took them two to three weeks to obtain an appointment. We saw the practice had identified in their action plan that they needed to appoint an additional GP.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Results from the NHS GP Patient Survey of the practice, published in January 2016, showed that patient satisfaction levels with telephone access and appointment availability were either above, or broadly in line with, the local CCG and national averages. Of the patients who responded to the survey:

- 95% said the last appointment they got was convenient, compared to the local CCG and the national averages of 92%.
- 83% were able to get an appointment to see or speak to someone the last time they tried. This was the same as the local CCG average and broadly in line with the national average of 85%.
- 76% found it easy to get through to the surgery by telephone, compared to the local CCG average of 78% and the national average of 73%.
- 78% said they usually waited 15 minutes or less after their appointment time, compared to the local CCG average of 71% and the national average of 65%.

Listening and learning from concerns and complaints

The practice had a system in place for managing complaints. This included having a designated person who was responsible for handling any complaints and a complaints policy which provided staff with guidance about how to handle them. Information about how to complain was available on the practice's website and was also on display in the patient waiting area. The practice had received 25 complaints during the previous 12 months. One of these was still in the process of being investigated. We looked at a sample of the records of complaints. We found patient complaints were taken seriously, and responded to promptly and appropriately. Where the practice had identified that it could have performed better, patients were offered an apology. There was evidence that lessons were learnt as a consequence of the complaints received. Complaint outcomes were shared during team meetings, to enable learning across the practice.

Are services well-led?

Good

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

Our findings

Vision and strategy

The leadership, governance and culture at the practice actively encouraged and supported the delivery of high-quality, person-centre care. The practice had a clear vision to deliver high quality care and promote good outcomes for their patients. Staff had devised an overarching mission statement which set out the practice's aims and ethos. The practice leadership team had met in April 2016, to agree a more detailed set of objectives. All of the staff we spoke to were aware of the practice's commitment to delivering good patient care, were proud to work for the practice and had a clear understanding of their roles and responsibilities.

Governance arrangements

Good governance arrangements were in place. Examples of these included the carrying out of evidence based assessments, the allocation of lead roles to staff to help promote good clinical leadership, and the holding of regular planned meetings to share information to manage patient risk. There were regular safeguarding, palliative care, significant event and clinical meetings. Members of the nursing team met monthly to discuss issues relevant to their nursing practice and to provide each other with peer support. The sample of minutes we looked at were very detailed and contained evidence of reflective practice and shared learning. Responsibilities for management, administration, accountability and reporting structures within the practice were well defined, and clearly understood by staff. It was clearly evident that staff at all levels were committed to helping the practice perform well.

Good arrangements had been made which supported staff to learn lessons when things went wrong, and to support the identification, promotion and sharing of good practice. Clinical audits had been carried out and staff were able to demonstrate how these had led to improvements in patient outcomes. The practice actively sought feedback from patients and also had an active patient participation group (PPG), which they encouraged to provide feedback on how services were delivered and what could be improved.

Leadership, openness and transparency

There was a clear leadership and management structure, underpinned by strong teamwork and good levels of staff satisfaction. The GPs, nurses and the practice management team had the experience, capacity and capability to run the practice and ensure high quality compassionate care. Staff we spoke with told us they felt well supported by the leadership at the practice. A culture had been created which encouraged and sustained learning at all levels. The provider had complied with the requirements of the Duty of Candour regulation. The partners encouraged a culture of openness and honesty. There were effective systems which ensured that when things went wrong, patients received an apology and action was taken to prevent the same thing from happening again. For example, we saw evidence that a patient had received a very full and detailed response to the concerns they had raised. (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).

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

The practice encouraged and valued feedback from patients and staff. They had an active patient participation group (PPG) of seven members, which provided a patient's perspective on issues, concerns and proposed developments at the practice. There was also a virtual PPG, consisting of 26 members, who had agreed to be contacted via email for their views about the practice, and to contribute to the construction of the practice's patient survey. Members of the PPG told us they felt their views and opinions were welcomed by the practice. We confirmed that a GP had been appointed in April 2016, to help address this concern. Patient feedback had also been gathered from patients through the Friends and Family Test survey. It was very evident that the GP partners and practice manager valued and encouraged feedback from their staff. Arrangements had been made which ensured that all staff received an annual appraisal.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking, and actively encouraged and supported staff to access relevant role-specific training. The team demonstrated their commitment to continuous improvement by:

Are services well-led?

Good

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

- Providing training placements for Foundation Year 2 trainee doctors, and practice and district nurses, to give them an opportunity to learn about general practice.
- Supporting a salaried GP to study for a diploma in dermatology. This included purchasing a specialist item of equipment to assist them with their case studies.
- Developing consulting room reference material to help clinical staff carry out more effective assessments of sick children.
- Ensuring most staff had received an annual appraisal, and the GPs had been appraised externally in the previous 12 months.
- Carrying out a good range of clinical and quality improvement audits.
- Learning from any significant events that had occurred.